

**Should I Stay Or Should I Go?  
Towards an Understanding of  
Leaving Nursing**

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I hereby declare that the material contained within this thesis is entirely my own work and has not been submitted towards any other degree or professional qualification.

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# Abstract

It is widely claimed that nurses are leaving the profession in large numbers. This is often cited as a result of a decline in commitment. However, in this thesis I argue that these commonplace understandings are mistaken. Through a qualitative analysis of in-depth interviews with 28 practising and ex-nurses, I paint a complex picture of how individual nurses' range of commitments need to be understood within the broader contexts and discourses of British nursing, workplaces and society. Participants in this study demonstrate powerful and conflicting feelings towards their work. A passionate commitment, often rooted in a concern for the welfare of others, is reinforced by the intense personal rewards that nursing offers, and a dominant occupational discourse of total commitment. This commitment demands a high level of physical and emotional endurance, a willingness to prioritise nursing over all else, and to sacrifice one's own needs in the service of others. However, these positive feelings are often accompanied by intense negative feelings of frustration, fear and powerlessness centring on participants' inability to fulfil their working commitments, and to balance them with other commitments in their lives. This thesis centres on the premise that nursing involves a life on the boundaries, a place of uncertainty and conflict as well as of challenge and opportunity. Nurses frequently find themselves caught on the boundaries between conflicting ideas and commitments, trying to fulfil expectations that are mutually exclusive. At the same time, they are faced with the task of negotiating their own boundaries in order to function in a world of limitless demands. Within a working role that has no clear boundaries they must seek to establish the nature and scope of their responsibilities in order to function. In an occupation that demands limitless commitment, they must negotiate the boundaries between their commitment to nursing and to other roles beyond the sphere of work. They must also negotiate the boundaries of the self, determining the extent to which they are willing or able to give of themselves, balancing expectations of the super-nurse with the limits imposed by being human. These negotiations occur in an environment of constant change, of conflicting ideals and high stakes where there are often no right answers. The task is further complicated by the organisational limits to nurses' authority, by a persistent discourse of the submissive and obedient nurse, and by the risks involved in challenging a dominant discourse of strength and coping. The complexity of nurses' situation leads them to adopt a range of survival strategies. Some stay and endure, while others seek respite in new posts or specialities. Those who lose hope may take advantage of childbearing to slip out unnoticed. Contrary to the popular belief in a mass exodus of nurses indicating a loss of commitment, it is often those with a powerful sense of commitment to caring for others who find the strength to leave nursing and seek satisfaction in other fields of work.

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*No lesson is harder to learn for the new nurse than that of discipline - the subordination of her will unquestioningly to that of another ... she must bend under a law which is by no means always a law of love; never ask 'why', and as seldom as possible 'how'; be content to bear unmerited blame without murmuring, to be scolded for mistakes that were made in all good faith; she must not be surprised to find herself vehemently repressed if she ventures on the faintest suggestion, and generally, if she is at all forward or clever she will be 'put in her right place' ... Among all the good qualities which a perfect nurse should possess, a little of that 'courage of endurance', that spirit of self-sacrifice, which was so important a point with the old religious sisters, would not be a bad thing. Cheerful obedience to discipline, the idea of accepting restraint in any spirit but a hostile one, loyalty to superiors, faithful submission to subordination are the very rarest virtues among them. Yet it is the spirit of self-sacrificing loyalty that leads to the highest and truest discipline ... that remains loyally silent over its own wrongs, and punctilious to a fault in the fulfilment of its duties ... no life is more hard to live nobly than a life of loyal servitude.*

*(Miss Mollett, a London matron, 1888, cited by Jolley and Brykczynska, 1993: 14)*

# Table of Contents

<b>Introduction</b>	10
<b>Chapter One, The State of the NHS Nursing Workforce: Current Perspectives and the Need for Further Research</b>	15
• Current Perceptions of the NHS Workforce	16
• Conflicting Perspectives on the State of the Nursing Workforce	25
• Government Policy Responses to the Most Recent Nursing Shortage	28
• Questioning the Accepted Picture	33
• The State of the Nursing Workforce	41
• Building on the Existing Research	55
<b>Chapter Two, The Research Process</b>	57
• Laying the Foundations	58
• The Research Process	80
<b>Chapter Three, Negotiating the Boundaries of Nursing</b>	120
• The Nurse – A Role Without Boundaries?	121
• A Role Without Boundaries: Conflict, Confusion and Challenge	113
• Negotiating the Boundaries of Nursing	150
• Conclusions	191
<b>Chapter Four, Negotiating the Boundaries Between Conflicting Commitments</b>	192
• A Total Commitment to Nursing?	193
• The Origins of a Total Commitment to Nursing	200
• Negotiating the Boundaries of Multiple Commitments	208
• Conclusions	216
<b>Chapter Five, Nursing as an identity: Negotiating a Commitment Without Boundaries</b>	217
• The Theory of Identity	218

• Experiences and Expectations of Being a Nurse	227
• Negotiating the Boundaries of Identity: The Strong Nurse Versus the Vulnerable Person	250
• Understanding the Discourse of the Super-Nurse	254
• Negotiating the Boundaries Between the Super-Nurse and the Human Being	263
• Conclusions	277
<b>Chapter Six, Responding to Life on the Boundaries</b>	<b>278</b>
• Weighing Up the Costs and Rewards of Nursing	282
• Nurses' Responses to Life on the Boundaries	296
• Conclusions	325
<b>Chapter Seven, Conclusions</b>	<b>326</b>
• A Context of Struggle	327
• The Meaning of Leaving	332
• Limitations of the Study and Opportunities for Further Research	333
• Implications of the Thesis	338
• Conclusions	348
<b>Appendix One</b>	<b>344</b>

# Abbreviations

ADL	Activity of Daily Living
CD	Controlled Drug
CHImp	Commission for Health Improvement
CNP	Clinical Nurse Practitioner
CNS	Clinical Nurse Specialist
CSBS	Clinical Standards Board for Scotland
CSP	Chartered Society of Physiotherapists
DoH	Department of Health
DHSSPSNI	Department of Health, Social Services and Public Safety for Northern Ireland
HA	Health Authority
HCA	Health Care Assistant
HDU	High Dependency Unit
HES	Hospital Episode Statistics
HESA	Higher Education Statistics Agency
ICN	International Council of Nurses
IWL	Improving Working Lives
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NMC	Nursing and Midwifery Council
NVQ	National Vocational Qualification
OECD	Organisation for Economic Co-operation and Development
PALS	Patient Advice and Liaison Services
PAM	Professions Allied to Medicine
PCG	Primary Care Group
PREP	Post Registration Education and Practice
P2K	Project 2000
RCN	Royal College of Nursing
RGN	Registered General Nurse
RMN	Registered Mental Nurse
RN	Registered Nurse
SEN	State Enrolled Nurse



SHA	Strategic Health Authority
SHO	Senior House Officer
SIGN	Scottish Intercollegiate Guidelines Network
SVQ	Scottish Vocational Qualification
TOIL	Time Off In Lieu
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
WTE	Whole Time Equivalent

# Introduction

Throughout the history of modern British nursing, the subject of shortages has been a recurring theme, shaping the development of both nursing and the health service. In recent years this concern has been associated with a belief that we are currently experiencing the effects of a mass exodus of nurses from the profession (e.g. Mackay, 1989: 178; Ball and Stock, 2000: x; Munro, 2002: 5), a phenomenon that is often associated with claims of a loss of commitment among nurses (e.g. Mackay, 1989; Peelo et al, 1996; Mackay, 1998; Dingwall and Allen: 2001). The aim of the study on which this thesis rests is to develop a deeper understanding than is available at present of the phenomenon of leaving nursing. A better understanding can then inform further debate within and between nursing, health service and policy making circles in order to strengthen the foundations upon which policy in all of these arenas is built.

Much of the existing literature concerning leaving nursing is based on statistical analysis and is concerned with the question of how many nurses are leaving. As I show in chapter one, the answers to this question are hampered by a number of factors that undermine the reliability and validity of the available figures. In contrast to this prevailing concern with numbers I look at the meaning that underpins the reported trends, basing my thesis on a qualitative analysis of the accounts of individual nurses and ex-nurses, and the socio-economic and political context in which they were produced. These accounts provide insights into both the reasons why many nurses express the desire to leave, and the rational and emotional factors that shape the career choices that they make in response to dissatisfaction. When one looks at the why, rather than the what of leaving nursing, this choice emerges as a measure of last resort rather than as the easy option it is often assumed to be. As such it takes on a much deeper significance than has previously been recognised, indicating the depth and severity of the problems faced by nurses, rather than a declining commitment in the nursing workforce.

The central thread running through the thesis is a powerful tension between the desire of many qualified nurses to leave nursing, and the factors that serve to hold

them within their chosen profession. This tension manifests itself as a contradictory and complex interplay of emotions. On one side there are feelings of frustration, fear and anger relating to the experience of nursing in the National Health Service (NHS); on the other side there are positive feelings of commitment to, and pleasure in, the work, augmented by more negative feelings of powerlessness and fear relating to the risks of acknowledging weakness and of leaving nursing for the unknown.

This thesis is structured around the idea that nurses' understandings and experiences of work are profoundly shaped by conflict over, and a lack of clarity in, the boundaries that shape and separate their working and personal lives. Boundaries are the socially accepted rules and norms that define the limits between one phenomenon or object and another, and are constantly negotiated and re-negotiated in our day to day activities and social interactions (Gumperz, 1982; Savage, 1995; Allen, 1998, 2001, 2004; Wicks 1998; Mullings, 1999; Leonard, 2003). Boundaries enable us to understand the world in which we live and so to function within it. For example, boundaries help us to define what is and is not nursing, what it is appropriate for a nurse to do, to think or to be. They define the nature of her<sup>1</sup> role, the scope of her responsibility, and the limits of physical space and time in which she can be expected to function as a nurse. Boundaries are also vital to a nurse's sense of self and of her place in the world. They help us to answer questions such as: Am I a nurse because of what I do or because of the way in which I think of myself? Should a nurse leave all the expectations of her working role at work, or should she carry them home and into her personal relationships and activities? The answers to these and many other questions are often unclear to nurses who are faced with the challenge of negotiating boundaries that are in a constant state of flux or contention (Rafferty, 1996; Allen, 1998).

In describing the uncertainty that nurses face I use the word 'negotiate' to describe their responses since this is a word that carries two separate and apposite meanings. First, negotiation describes a process of bargaining between groups or individuals. At the heart of this thesis is the tension between nurses' experience of a lack of clear

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<sup>1</sup> Throughout this thesis I use the female pronoun in preference to the unwieldy he/she since the nursing workforce is predominantly female. In choosing to use 'she' I do not seek to deny the presence of men either among the ranks of nurses or among the participants in this study. Instead I hope that it will help to throw into relief the experiences of male participants who work within a world constructed around ideas of femininity, caring and self-sacrifice.

boundaries and their need to clarify their situation in order to function both as nurses and as human beings. In order to achieve this clarity, nurses engage in a great deal of negotiation on many levels. As a group they negotiate their boundaries with other professions as well as with managers and policy makers. Negotiations also occur within nursing between groups with differing perspectives on the boundaries of their role. As individuals, nurses are also involved in negotiations on a daily basis with other members of the multi-disciplinary team, with managers, patients, relatives, and with each other. As people attempting to balance multiple roles they also engage in negotiations with people beyond the workplace when the boundaries between their private and working lives come into conflict.

Second, the word negotiate can also be used to describe a progress through difficult terrain when one has to avoid many obstacles, some of which may be hidden. This meaning is also relevant for nurses who are daily faced with the task of making choices in situations where boundaries are always shifting and are often strongly contested. The frustration and fear expressed by many of the participants in this study is a manifestation of this uncertainty, existing in tension with the enormous rewards that they describe. In the chapters that follow I explore this individual experience of tension against the wider context of nursing in Britain, and in Scotland in particular, in order to illuminate the complex interplay of factors that shape nurses' orientation to leaving nursing.

In chapter one, *The State of the NHS Nursing Workforce: Current Perspectives and the Need for Further Research*, I situate this study within the broad context of nursing in Britain with particular reference to the Scottish NHS. I also explore our current understanding of both the state of the nursing workforce and the phenomenon of leaving nursing. In this I draw on official statistical data and reports, on academic research papers and on popular understandings of the issue of leaving nursing as expressed in the media. I conclude the chapter by arguing that this study builds on the insights provided by previous researchers to develop a deeper and more complex understanding of the phenomenon of leaving nursing.

In chapter two, *The Research Process*, I describe the critical hermeneutical approach to research that underpins this study and the epistemological position on which the

study rests. I then describe the research process from its inception to the writing of the final thesis.

In chapter three, *Negotiating The Boundaries Of Nursing*, I explore nurses' experiences of negotiating the boundaries of their working role in order to illuminate the high levels of dissatisfaction described above. I describe the dominant discourse of the role of the nurse in order to demonstrate what it is that nurses are trying to achieve. I then explore the ways in which they have to negotiate with other groups in order to achieve their ideals and the power imbalances that lie behind the strong feelings of frustration, fear and anger that run through their accounts.

In chapter four, *Negotiating The Boundaries Between Conflicting Commitments*, I explore the relationship between a commitment to nursing and the other commitments in nurses' lives. I describe a discourse of nursing that demands a total commitment to work and which conflicts with nurses' other commitments, in particular parenthood. I explore the origins of this discourse of a commitment to nursing and the factors that serve to perpetuate it as well as the implications for individual nurses and for the implementation of 'family friendly policies'.

In chapter five, *Nursing As An Identity: Negotiating A Commitment Without Boundaries*, I address the expectation of total commitment from the perspective of nurses' sense of identity. I show how the discourse of total commitment is understood in terms of a willingness to identify with the role of the super-nurse and the way in which this has the potential to edge aside any consideration of nurses as real and vulnerable people. In this way the discourse of commitment shapes nurses' willingness to ask for help or to consider leaving.

In chapter six, *Responding To Life On The Boundaries*, I move on from a concern with the sources of nurses' dissatisfaction to a detailed exploration of their responses. I show how these responses reflect a tension between the significant costs and the powerful rewards of nursing. I argue that leaving is only one of the options that nurses choose and that, far from being an easy way out for the weak and uncommitted, it is an extremely difficult choice that is often made by those with the highest ideals or who retain a strong sense of self preservation.

In chapter seven, *Conclusions*, I draw together the analysis presented in the previous chapters. I highlight the main themes and issues arising from the study, its

limitations and areas for further research that arise from it. I finish with a consideration of the implications of the study for those in both policy making and nursing circles.

# **Chapter One**

## **The State Of The NHS Nursing Workforce: Current Perspectives And The Need For Further Research**

In this chapter I set out the broad context of NHS nursing within which this study is set as an essential aspect of the hermeneutical approach to research that I have taken. This approach involves the analysis of individual nurses' accounts within the context of their production. These accounts can be partially understood within the changing context of the nursing profession, but nursing itself is shaped by, and contributes to, policies and debates within the NHS. In turn, these changes in the health service also reflect broader debates and trends in society, politics and the economy. These contextual factors are summarised in appendix one and a more detailed consideration of the factors shaping nurses' experiences and accounts is woven throughout the fabric of the thesis.

In describing our current understanding of the nursing workforce I draw on both governmental and professional statistics as well as academic research papers. The purpose is not simply to provide a literature review but to highlight the problems with our present understanding and to distinguish between knowledge based on solid research evidence and assumptions that are rooted in common-sense understandings of the world. In so doing I clarify what we do and do not know about the current state of the nursing workforce and the phenomenon of leaving nursing, and highlight those areas in which further work is needed. I finish by identifying the place of this study in the existing body of work and arguing that it builds on the existing research, addressing some of the gaps in our knowledge and the methodological problems described in the rest of the chapter.

## **CURRENT PERCEPTIONS OF THE NURSING WORKFORCE**

### **STUDYING BRITISH NURSING FROM A SCOTTISH PERSPECTIVE**

One key aspect of the political context of this study that needs to be identified as being of particular significance is the devolution in 1999 of health policy, from Westminster to the Scottish Parliament. Much of the literature describing the NHS workforce is based on English data and does not identify variations between the four countries of the UK. Although the fact that the UK wide remit of the NHS until devolution meant that much of the organisational culture and history are held in common, broader regional variations in culture, economics and politics make each country subtly different. These variations have been widened by differing approaches to health and education policy since devolution. These are set to widen further with the announcement of a new health reform package in Scotland in November 2005 (Scottish Executive, 2005). Although the interviews on which this thesis is based are dominated by the experiences of Scottish nurses, several participants compare their experiences in England and Scotland, providing some link between the two settings. The dominance of England in the UK necessarily means that many of the written sources that I draw on reflect the English system. However, many comparisons can be made between formal texts describing English nursing and the experiences of Scottish nurses. Where possible I highlight the relevant similarities and differences between Scotland and England. I also include specifically Scottish statistics where this is possible but in many cases these are no separate statistics or they are not compiled in ways that allow comparisons across the border. Unless I specify otherwise, any references to the NHS apply across the UK rather than to NHS Scotland in particular.

### **A STATISTICAL OVERVIEW OF BRITISH NURSING, 1990 - PRESENT DAY**

The context within which this study originated and was conducted (1999-2003) was one of considerable concern regarding the quality of service provided by the NHS across Britain and, in particular, the impact of nursing shortages on patient care. These concerns arose in response to a lengthy period of dramatic and ongoing change, with the marketisation of the NHS under the Conservative Governments of the 1990s, and the advent of the reformist New Labour Government in 1997.



Indeed, over the past fifteen years, change has become a permanent characteristic of the NHS and the number of Government policy documents has increased exponentially. Some idea of the complexity and scope of health policy production can be gained by visiting the Department of Health (DoH), Scottish Executive or Northern Irish Department of Health, Social Services and Public Safety (DHSSPS) websites where all new policy papers are listed. The increasing volume of health policy production is in itself a significant aspect of the context of this study. For example, many GPs are reported to be unwilling to sign up to reforms in primary care budgeting:

There has been so much change in the last few years, doctors are unsure how long this initiative is going to last so many are reluctant to dive in. (BBC, 2005a)

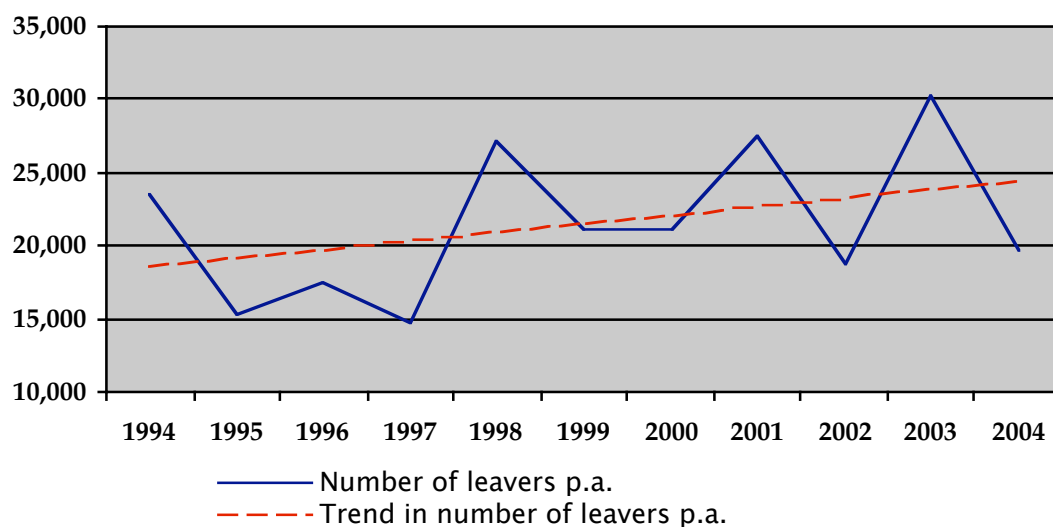
Sergeant (2003) claims that the growth of policy production has created a situation in which managers often greet new 'initiatives' with cynicism, expecting one panacea to be swiftly displaced by the next. The pace of change also places a strain on the nursing staff who are expected to respond to it.

During this period of change and increasing demands newspapers and professional journals alike have presented a picture of a NHS that is staffed by exhausted, underpaid and demoralised nurses, and which is in danger of imminent collapse. Indeed we have become accustomed to reading dramatic headlines such as 'Angels Losing Faith in the NHS' (Kennedy, 2001), 'One in Ten Nurses is 'Leaving NHS' (BBC, 2004a), or 'Recruits to Nursing Must Double' (BBC, 2005b). The effect of these high profile problems is shown in a report from 2003, which claims that the public associates the NHS with staff shortages and intense work pressure more than with caring (DoH, 2003b).

At the heart of the debates regarding the state of the NHS lies the key issue of nursing shortages and the related phenomena of high levels of stress, wastage, turnover and sickness absence. At the inception of this study, in 1999, there was general agreement between the Government, NHS and nursing bodies that Britain was facing a serious national shortage of nurses. Between 1990 and 2000, the number of nurses registered with the United Kingdom Central Council for Nurses,

Midwives and Health Visitors (UKCC)<sup>2</sup> dropped by 170,000 (Buchan and Seccombe, 2002: 21). Furthermore, an analysis of UKCC figures indicated that the number of nurses leaving the register annually increased threefold from 7,173 in 1997/8 to 21,174 in 1998/9 (Millar, 2000: 18) and reached a peak of 30,219 in 2003 (NMC, 2003). The rising trend in the number of people leaving the register over the past decade is illustrated in graph one.

**Graph One: Number Of Nurses Leaving The NMC Register, 1994-2004**



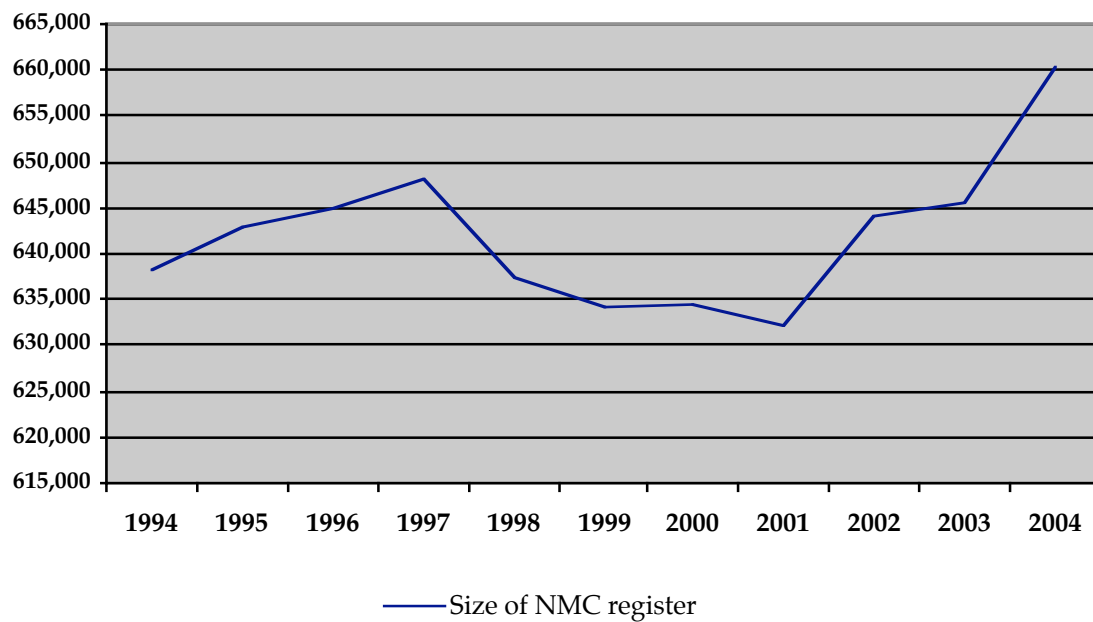
(Based on statistics from NMC, 2004)

Although graph one shows a general upwards trend in the number of nurses leaving the register each year, there is a great deal of fluctuation around this trend which gives rise to questions regarding the severity and even the existence of an 'exodus' from nursing. This is an issue that I return to later in this chapter.

Graph two illustrates the effect of the trend shown above on the size of the NMC register during the same period. These figures are seen as being particularly relevant since they represent the total pool of UK nurses from which employers can recruit.

<sup>2</sup> Until 2002, the UKCC was the professional body representing nurses and, as such, it was responsible for maintaining a register of all the practising nurses in the UK. In 2002 the Nursing and Midwifery Council (NMC) replaced the UKCC and the four National Boards for Nursing.

**Graph Two: Size of NMC Register, 1994-2004**

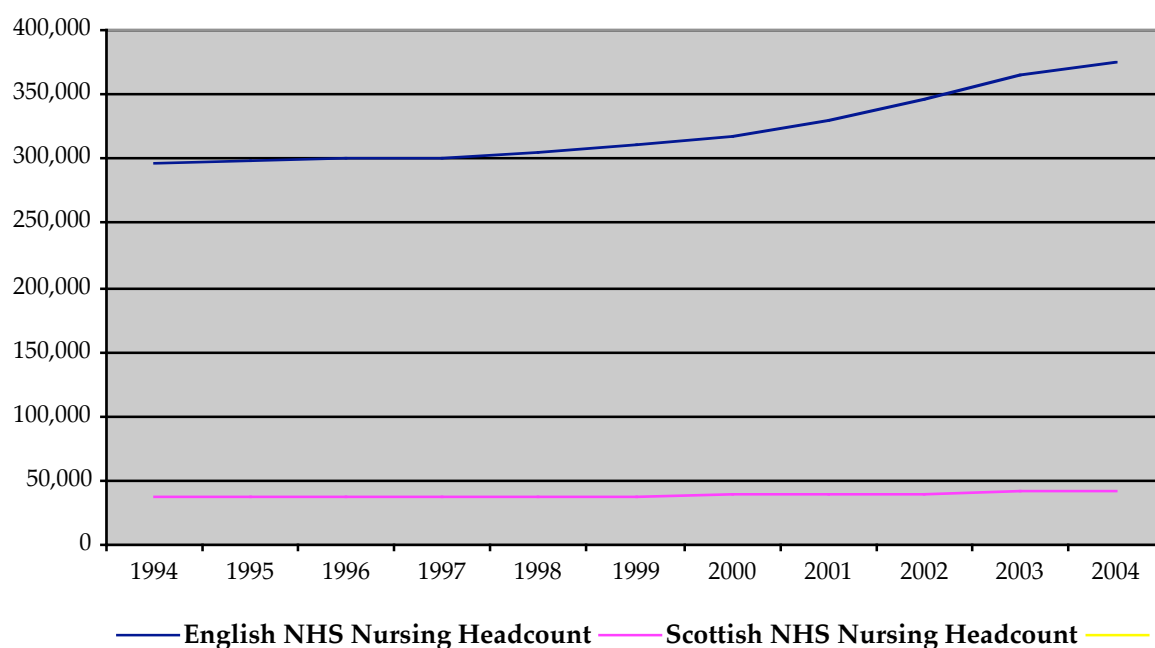


(based on statistics from NMC, 2004).

This graph indicates a decline in the size of the register from 1997 until 2001, which corresponds with the increasing number of leavers seen in graph one. The sudden reversal of this trend from 2001 onwards coincides with the Government's recognition of widespread shortages at this time and the introduction of a range of policies designed to increase both the size of the NMC register and the number of nurses employed by the NHS. This upturn suggests that these policies compensated to some degree for the continuing loss of nurses from the register. However, care needs to be taken in interpreting these figures since other factors may well have contributed to the rise in numbers. Nevertheless, the NMC figures, combined with an increase in the number of nurses employed by the NHS, underpin claims made by Government ministers that, due to the success of their policies, the nursing shortage is now over (BBC, 2004b). This growth in both the English and Scottish NHS nursing workforces can be seen in graph three which represents the headcount, or absolute number of nurses registered over the past decade. This form of statistical description needs to be distinguished from alternative sources that describe the workforce in terms of whole time equivalents (WTEs). Such figures are calculated by dividing the number of hours that staff are

contracted to work by the standard hours for their grade. Both sources have their limitations since the impact of a rising headcount may be less than it appears if a substantial proportion of those included work part time. WTE figures give a sense of the hours worked but not of the real number of individuals described.

**Graph Three: NHS Nursing Workforce Headcount for England and Scotland 1994-2004**



(Based on statistics from DoH, 1994 - 2005; Scottish Executive, 1994 - 2005).

Although the NHS nursing headcount in both countries grew during the decade described, the rate of growth in Scotland was much slower, a fact that the large variance in the relative sizes of the two workforces exaggerates on the graph. In Scotland an annual growth rate of just 0.4% has led to doubt being expressed as to whether the Scottish Executive's recruitment target of an extra 12,000 nurses by 2007 can be met (Royal College of Nursing (RCN), 2004c). The present trajectory indicates that there will be only 4,000 extra nurses by 2007 (ibid.). As I show later in this chapter, the RCN's concern over this projected shortfall is part of a wider dispute between Government and professional bodies over both the accuracy of the official statistics and of the claim that the nursing shortage is now over. This

current dispute is just the latest manifestation of an ongoing conflict that reaches back to the beginning of modern nursing.

## **NURSING SHORTAGES IN HISTORY**

The nursing shortage of the late 1990s and early 2000s is by no means a new phenomenon. Rather it is the latest episode in a repeated cycle of shortages and interventions stretching back to the latter part of the nineteenth century. For example, Baly claims that during the first seven years of the Nightingale Training School, which opened in 1860, it struggled to cope with a student wastage rate of 40% (Baly, 1991). Buchan describes 'repeated cycles' of nursing shortages throughout the twentieth century, the most recent occurring in the mid 1980s and again in the late 1990s (Buchan, 1998). Concerns regarding these shortages have shaped the development of both the health service and nursing since the earliest days of modern hospital nursing. For example, Carpenter (1977) argued that a shortage of nurses in the late nineteenth and early twentieth century led to a situation in which nursing was forced to make concessions on the age of entry, reductions in hours, and pay increases. After World War Two, another nursing shortage led to further concessions in which male, married, and part time nurses were allowed to practice for the first time. In the 1960s, when career opportunities for women expanded, nursing shortages led to the first large-scale recruitment of nurses from overseas (Carpenter, 1977).

## **ACCOUNTING FOR NURSING SHORTAGES**

Most attempts to explain the most recent nursing shortage centre on the decline in the total number of nurses registered to practice during the late 1990s. This can be attributed to an imbalance between the number of new entrants to the register and the number of qualified nurses exiting the profession. Nursing shortages are widely presumed to result, in part, from high levels of wastage as large numbers of disaffected nurses leave the profession each year. For example, the RCN claims that the NHS is 'running hard to keep still' (RCN cited by BBC, 2004b) and that nurses 'are coming in the front door' but 'falling out the back' (Malone, cited by BBC, 2005b) to such an extent that the Government must double the annual level of

recruitment in order to maintain current staffing levels (RCN, 2005a). The RCN attributes this ongoing wastage to a series of sources of dissatisfaction including high levels of stress and overtime and increasing workloads (ibid.).

Although there is no direct evidence providing a breakdown of the reasons why nurses do not renew their registration, repeated surveys during the past decade show a widespread desire to leave nursing that has persisted despite the growth in the size of the nursing workforce. A UNISON survey, conducted in 1997, claimed that approximately 67% of nurses at that time wished to leave nursing (*Health Service Journal*, 1997: 4). The figures produced in the annual RCN membership survey<sup>3</sup> are lower but still indicate a serious problem with the number of nurses expressing the desire to leave ranging from 25% in 1993, to a peak of 38% in 1996 (Ball and Stock, 2000: 46). High levels of dissatisfaction are also reported in the 2005 RCN survey which reports that 47% of all respondents, and 48% of those working in the NHS, would leave nursing if they could (Ball and Pike, 2005: 83). In 1998, the figures for Scotland indicated that 43% of nurses would leave nursing if they could (RCN, 1998). References to an 'exodus' of nurses are common in research reports and news articles (e.g. Mackay, 1989: 178; Ball and Stock, 2000: x; Harte, 2000; Munro, 2002: 5; BBC, 2005c) and have also become part of the everyday language of nurses themselves (e.g. Anonymous Nurse, 2000a). The common use of this word reflects the widespread assumption that many disaffected nurses are acting on their expressed desire to leave.

The impact of the loss of dissatisfied nurses on the size of the workforce is augmented by the increasing proportion of nurses reaching retirement age each year. Buchan claims that, between 1991 and 2000, the number of nurses under the age of thirty halved, and that in 2000 one in five nurses were over the age of fifty (Buchan, 2000b: 818-819). This rose to 23% in 2003 (Ball and Pike, 2003: 14). Given that nurses have the opportunity to retire at fifty-five, there are major implications in terms of the impending retirement of such a large proportion of the workforce. The problem is further exacerbated by the fact that a third of NHS nurses retire

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<sup>3</sup> Unless stated otherwise, figures drawn from the annual RCN survey relate to the entire UK nursing membership. Variations in the focus of the survey from year to year mean that it is not always possible to make comparisons between different years. This variation also means that a breakdown of the statistics from the four nations may be present in one survey but absent in others.

early on medical grounds, most commonly as a result of 'the toll of too much pressure', at an average age of only 52 years (ibid.: 59). In addition to the impact of these changes on the total workforce, shortages are felt more acutely in certain specialities since older nurses are concentrated in areas such as the care of older people (Buchan, 2000b) and primary and community health care, where 68% of nurses are over the age of forty (Ball and Pike, 2003: 52).

As increasing numbers of nurses leave the register, the number of new registrants from the UK has been unable to compensate for these losses, despite recent improvements in the number of pre-registration students in training. These improvements follow a decline in the number of new registrants in the late 1990s. This occurred as a consequence of the decision to delegate decision making regarding the number of student placements to the newly created NHS Trusts in the early 1990s (Buchan, 1998). This move away from centralised control of the number of student places led to a situation in which many Trusts underestimated the numbers of students needed and so reduced the places available for training (Buchan, 2000d). The shortage of newly qualified UK nurses that this policy contributed to was exacerbated by a decline in the traditional recruitment pool of female school leavers. This ongoing challenge to recruitment is due to both demographic changes and competition from alternative sources of employment that many women find more attractive than nursing (Bacon et al, 2000). Furthermore, the move to a system of bursaries rather than salaries for student nurses, which accompanied the move of nurse training into higher education in 1992 with Project 2000<sup>4</sup>, has stimulated a public debate regarding the financial hardships involved in nurse training (Voller, Gibbs and DeMarco, 2002; RCN, 2003a; Thomson, 2005; BBC, 2005d). It seems likely that the high public profile of student nurses' financial difficulties creates further disincentives to those contemplating nursing as a career.

Despite these problems, an emphasis on increasing training places and improving recruitment has had some success in reversing the trend. Recruitment levels in England were at a five year high in 2004 (Buchan and Seccombe, 2004: 39) although

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<sup>4</sup> Project 2000 (P2K) replaced the earlier college based training with a diploma level course accredited by a university. P2K places a greater emphasis on theoretical aspects of nurse education, as opposed to training; salaries were replaced by student bursaries and students became supernumerary in their work placements for the first time.

the long term significance of this apparent success may be limited as growth in student numbers slowed down in the three years leading up to this peak (*ibid.*: 39). The picture in Scotland at present is positive with an increase in the overall number of places for pre-registration diploma training of 4% between 2000/1 and 2001/2 and of over 8% between 2001/2 and 2002/3 (Buchan and Seccombe, 2004: 38). Applications for these places increased by 11% in the latter period (*ibid.*: 38). However, despite the consequent rise in the supply of newly qualified British nurses, these improvements are still not sufficient to replace those lost to the register each year (*ibid.*).

In addition to the problems of recruiting sufficient numbers to fill training places, the failure to replace those lost to the register is also attributable to the high levels of student wastage that have persisted across British nursing from the time of Nightingale to the present day. Reliable statistics describing trends in the numbers of students discontinuing their training are not available, due to the lack, until recently, of a centralised data collection system using a single definition (Buchan and Seccombe, 2004). The Higher Education Statistics Agency (HESA) is now administering a new attrition data collection system using a single definition but it will not be possible to identify trends from this data for several years. However, studies seeking to clarify this area suggest an average rate of around 20% student wastage per year to date (*ibid.*). In addition, it is claimed that many of those who do complete their training choose not to register and move into other areas of employment instead (e.g. Dinsdale, 1998; Robertson 2005). However, in this area too the statistics are not clear since the current data collection systems do not allow us to separate these nurses from those who drop out of training before qualifying (Dinsdale, 1998).

## **CONFLICTING PERSPECTIVES ON THE STATE OF THE NURSING WORKFORCE**

Thus far I have focused on the predominant concern of successive Governments with the absolute number of nurses registered to practice, and their claim that successful recruitment policies have solved the shortage (BBC, 2002a; BBC, 2004b).



However, others contest this, presenting statistics that suggest a continuing crisis. For example, in Scotland, a report compiled by Audit Scotland in 2002 stated that 50% of Scottish wards were understaffed (Auditor General (Scotland), 2002); the 2003 RCN survey claimed that only 26% of nurses reported that there were sufficient staff in their workplaces to provide a good standard of care, and 65% stated that their workload was too heavy (Ball and Pike, 2003: 33). Concerns continue to be expressed regarding the number of nurses retiring (*ibid.*), leaving the profession (*ibid.*) or moving abroad to practice (BBC, 2004b). These challenges reflect alternative ways of viewing nursing shortages and take into consideration factors such as variations in the supply and demand for nurses between different geographical regions and specialities.

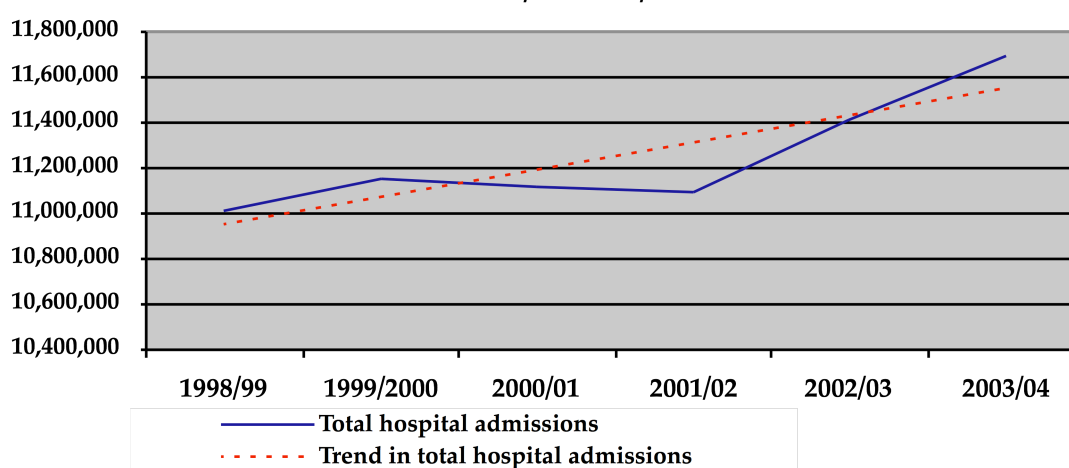
The importance of considering the demand for nurses as well as their supply in any explanation of the most recent nursing shortage is stressed by Buchan (1998), who claims that previous shortages occurred when the growth in the number of nurses failed to keep pace with the demand for their services. However, he argues that the shortage of the late 1990s differed in that it was more severe, and that it originated in a decline in the number of nurses at a time when the demands made upon the NHS were increasing dramatically (*ibid.*:23). The key question, according to this perspective, is not whether the number of nurses is rising or falling, but whether any increase in numbers is sufficient to keep pace with the increasing workload, and whether those nurses available for employment have the necessary skills to match the demand in particular areas.

The demand for nurses in terms of absolute numbers and of particular skills has expanded significantly over the past decade as the result of a number of factors. The introduction of new services such as NHS Direct, and the growth of the private care home sector (Buchan and Edwards, 2000) have created new areas of employment that compete with existing services to recruit nursing staff. Furthermore, the recommendation of the European Working Time Directive, that junior doctors should not work more than 56 hours per week, or 72 hours including on call time, became legally binding on hospital Trusts in 2003 (BBC, 2003a). This has contributed to a broadening in the scope of nursing practice, augmenting a move

from within nursing itself to expand and develop the role of the nurse. This change is reflected in the role of the new specialist nurses taking part in this study.<sup>5</sup>

In addition to this expansion in the nursing role, the demands upon the NHS are growing as the proportion of elderly people in the population, who make greater use of the NHS, increases. In England, hospital admissions showed an increase of 23% between 1990 and 1998 (Buchan and Edwards, 2000: 30) a trend that has persisted as shown in graph four.

**Graph Four, English NHS Hospital Admissions  
1998/99-2003/04**



(based on statistics from Hospital Episode Statistics (H.E.S.), 2004)

Comparative figures for the total number of hospital admissions in Scotland are not available since the data is broken down into categories of admission that cannot be recombined into an accurate total. However, since Scotland experiences similar demographic trends and changes in healthcare provision to England, the existence of a similar increase in the overall workload carried by Scottish NHS nurses seems likely.

In addition to an increase in the volume of patients, the move towards earlier discharge has led to an increase in the level of dependency of hospital patients (NHS Confederation, cited by Ball and Stock, 2000) as those who are convalescing, or who have less acute needs, are cared for at home by community nurses. The size

<sup>5</sup> Nurse specialists fulfil a wide variety of roles under a range of different titles. Participants in this study refer to themselves as Clinical Nurse Practitioners (CNP) or Clinical Nurse Specialists (CNS). or Clinical Development Co-ordinators (see table three in chapter two). The function and titles of these nurses are contested (e.g. Legge, 2002). For this reason, when referring to this senior group of nurses, I use the generic term 'specialist nurse'.

and intensity of community nurses' caseloads have also increased as a result of the move to provide home based palliative care for terminally ill people, and of the involvement of these nurses in administering complex medical treatments to chronically ill patients who until recently would have been hospitalised. This complex interplay of demographic and policy trends has combined to create a situation in which increasing workloads have become one of the key sources of dissatisfaction cited by nurses across the NHS.

The increase in nurses' workloads may be a contributory factor in another aspect of shortages described by Brown and Keep (1999) who claim that the term 'shortages' may reflect a mismatch between people's skills and the jobs they perform, as well as an absolute lack of people with the requisite skills. In support of this claim, they cite Edwards et al (1998) who have found that many people, including large numbers of nurses and teachers, choose to work in areas that do not make use of their training because they are not prepared to accept the conditions in which they would have to work to use those skills. This description of the choices that people make in their employment may, in part, explain the trends towards an increase both in the number of qualified nurses who leave the register each year and those students who qualify but choose not to register.

## **GOVERNMENT POLICY RESPONSES TO THE MOST RECENT NURSING SHORTAGE**

The severity of the situation within the NHS during the late 1990s and early 2000s is demonstrated by the fact that, the Government, the NHS, the unions, healthcare professionals and the general public all agreed that the NHS was facing a severe shortage of nurses. Indeed, in 2000, the Health Secretary, Alan Milburn stated that:

Individual nurses have told me that they have found themselves in the position of being the only qualified person looking after 30 sick, highly dependant, patients ... Little wonder then that staff sometimes feel it is not possible for them to do their job. (Milburn, cited by O'Dowd, 2000a: 5)

The extent to which the Government recognised, and sought to act upon, concerns regarding nursing shortages was particularly significant given the previous

reluctance of governments to recognise national shortages at all. As both Buchan and Seccombe (2002), and Ball and Stock (2000) note, this change of heart may have reflected the threat that nursing shortages posed to the achievement of the Government's health targets and its plans for reforming the NHS, at a time of rapidly increasing workloads. This acceptance that the NHS faced a serious nursing shortage led to the implementation of a range of policies designed to increase the number of practising nurses. In England a new recruitment and retention unit was created in 1999 within the DoH, and recruitment targets were set out in the Priorities and Planning Framework 2003-2006. The DoH claims to have met targets of 20,000 more nurses between 1999 and 2004, 20,000 more nurses between 2000 and 2005, and 35,000 more nurses, midwives and health visitors between 2001 and 2008 (DoH, 2005b). At times, these figures have been challenged on the grounds that the DoH engages in double counting to produce more impressive results (Carvel, 2000). In Scotland, as I indicate above, criticisms of the Scottish Executive centre more on the low rate of growth and predicted failure to meet future targets than on the accuracy of their statistics.

In order to achieve these recruitment targets, policies were introduced throughout the UK that sought to persuade practising nurses to continue nursing or to return to practice after maternity leave (e.g. DoH, 2000; Scottish Executive, 2001). These included the introduction of targeted wage increases, which were achieved by removing incremental points from the bottom of a grade and adding points at the upper level. In 1999 this led to salary increases of between 8 and 12% for D grade nurses (Ball and Stock, 2000: 32). In 2000, those on the top increment of an E grade were awarded 7.8% while every other nurse of D grade and above was awarded 3.4% (Nursing Standard, 2000a: 4). The targeted nature of these awards created some resentment among nurses and inconsistencies in pay that I describe in chapter four. More recently, there has been a radical reform of pay and grading structures across the UK with the introduction of *Agenda For Change* in 2004 (DoH, 2004a; Scottish Executive, 2003; RCN, 2004a). This UK wide programme has a broad remit, addressing issues surrounding career progression and role definitions as well as pay and conditions (Buchan, 2000a; DoH, 2004a; RCN, 2004b; RCN, 2004a). Other policies designed to enhance career opportunities for nurses included the creation of more specialist nursing posts and innovations such as consultant nurses (Scottish

Executive, 2001; DoH, 2003c) and modern matrons (DoH, 2001). Policy makers also focused on the need to persuade nurses to return to work after maternity leave, for example through the *Return to Practice Scheme* initiated in 1999 (DoH, 2005c), and by encouraging employers to offer suitable childcare and flexible working hours (Scottish Executive, 2001). In order to encourage flexible working practices in England, the DoH introduced a programme entitled *Improving Working Lives* (IWL) in 2001 with the target of implementing such practices in every English NHS Trust by April 2003. One of the criteria for achieving the IWL standard is that Trusts should provide evidence that:

they understand staff work best for patients when they strike a healthy balance between work and other aspects of their life outside work. (DoH cited by Leifer, 2003: 15)

Although many Trust websites offer evidence that they have responded to this initiative, and the DoH claims that improvements in the provision of childcare for NHS employees have improved recruitment and retention (DoH, 2004b), no independent assessment of the programme has yet been conducted. It is therefore likely to be some time before any meaningful conclusion can be reached regarding the success or otherwise of IWL at the national level.

In Scotland difficulties in recruiting sufficient nurses have stimulated suggestions for changes in policy that are currently the source of much debate. These include a proposal that the age of retirement for nurses should be increased from 60 to 65, and that more flexible pensions would allow nurses to phase their retirement and so extend their careers (Scottish Executive, 2004a). However, RCN Scotland has opposed these proposals on the grounds that they do not address the causes that contribute to so many nurses choosing early retirement, and that the consequent reduction in pension size would make nursing a less attractive career choice (RCN, 2005b).

While these policies seek to improve the retention of nurses, the main policy focus across the UK has been on improving recruitment. The RCN's most recent review of the nursing labour market illustrates the success of the English recruitment policies, but also highlights the lack of data by which policies aimed at improving retention can be evaluated (Buchan and Seccombe, 2004). While the increasing number of new British registrants has contributed to the expansion of the nursing workforce, the bulk of this increase reflects a substantial rise in overseas

recruitment (ibid.). UKCC figures show that the percentage of new registrants from overseas rose from 1% in the early 1990s to 25% in 2000/2001 (Buchan and Seccombe, 2002: 19), and the 2003 RCN membership survey shows that 6% of all respondents first qualified outside of the UK (Ball and Pike, 2003: 13).

This trend has been controversial because many of the new registrants have been recruited from countries like South Africa, which are currently experiencing their own serious nursing shortages. In 2001 only 75% of the available positions for nurses in the South African public health sector were filled (Hall and Erasmus, 2003: 537), and Deane echoes Mackay's words describing South African nurses as an 'endangered species' (Deane, 2003). As a result of widespread criticisms of both the practice of recruiting from developing countries and the treatment of nurses from overseas, the DoH has sought to distance itself from aggressive overseas recruitment drives conducted by some NHS Trusts and other employers. In 2001 guidelines for good practice were issued that encourage Trusts to target only those countries that are not experiencing shortages of nursing and medical staff (DoH, 1999a). In 2003 the code was updated to limit the approved recruiting grounds to those countries with which Britain has a bilateral agreement, and to limit the use of recruitment agencies to an approved list (Buchan and Seccombe, 2004). However, the impact of the code was limited to the NHS until 2004 when the DoH expanded the guidelines to cover all healthcare providers (ibid.). It also continues to be limited to English healthcare providers although there have been calls for the implementation of a separate Scottish code (RCN, 2004d). The voluntary nature of the code, and a lack of records describing overseas recruitment in the NHS, mean that it is not possible to monitor compliance. Consequently, in 2002/03 one in four new overseas registrants came from developing countries on the banned list, with more than 2,800 originating from sub-Saharan Africa. South Africa remains consistently in the top three target countries, supplying 32% of new registrants recorded in the 2003 RCN membership survey (Ball and Pike, 2004).

At home, the RCN has also criticised the reliance on overseas recruitment as a short term solution that fails to address issues of nurses' pay, career development and working conditions (Malone<sup>6</sup> cited by BBC, 2003b), a concern that is shared by Meadows et al (2000). Buchan (2000c) describes overseas recruitment as a short

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<sup>6</sup> Dr Beverley Malone is the current General Secretary of the RCN.

term and costly solution while the International Council of Nurses (ICN) has condemned this approach to solving staff shortages on the grounds that:

[Overseas recruitment will] delay effective local measures that would improve recruitment, retention and long-term human resource planning. (ICN, 2000: 33)

Although overseas recruitment has contributed substantially to the growth in nursing numbers, these advances are argued to be temporary and fragile since a survey conducted by the Kings Fund and RCN indicates that two in five overseas nurses plan to leave the UK (BBC, 2005c). If this is so, the current high levels of overseas recruitment will need to be sustained in the long term if domestic factors are not addressed sufficiently. The criticisms regarding the ethics of recruitment from developing countries are therefore likely to persist.

In addition to the recruitment of nurses from overseas, the growth in the size of the NHS nursing workforce can also be attributed to a steep rise in the number of agency and bank nurses employed.<sup>7</sup> Between 1999 and 2003 there was an increase of 36% in bank nurses, and in 2003 bank nurses accounted for one in ten of the total English nursing workforce (headcount), and one in five in London (Buchan and Seccombe (2004). Unfortunately, comparative figures for the other countries of the UK are not available due to variations in definitions and data collection. In addition to the increase in nurses employed solely by nursing banks, the annual RCN membership survey indicates a steep rise in the number of nurses using bank work to supplement their income from other nursing posts. The 2000 survey shows that at that time 10% of respondents worked on the nursing bank for their own employer, while 5% worked on the nursing bank of another employer (Ball and Stock, 2000: 23). Although directly comparable figures are not given in the 2003 survey, a sense of the increase can be gained from the claim that 86% of respondents had another job in addition to their main post, mainly in nursing banks (Ball and Pike, 2004: 32).

Alongside the practical implications of a shift towards more temporary staff, which I describe in chapter three, the rising use of agency staff has had enormous financial

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<sup>7</sup> A nursing bank is an organisation within an NHS Trust that employs nurses who work on an *ad hoc* basis, providing cover when there are insufficient permanent staff to cover a shift. Some only work occasional shifts while others are permanent members of staff elsewhere within the Trust and use bank shifts to supplement their income. Agencies are private companies that supply nurses when needed and as such are a more expensive way of employing temporary staff.

implications. In England, spending in this area almost tripled between 1997/98 and 2002/03 from £216m to £628m (Buchan and Seccombe, 2004). Figures released by the Scottish Executive show that more than £28.1 million was spent on agency nurses in the financial year 2002/2003 (Scottish Executive, 2003), and spending on agency and bank staff more than doubled between 2000/01 and 2003/04 (Buchan and Seccombe, 2004). In an attempt to reduce these costs the DoH set up NHS Professionals in England, and in 2003 the Scottish Labour Party announced its plans to set up an NHS nursing bank (BBC, 2003c). However, despite these moves, there is little evidence to suggest a shift away from expensive agency staff towards the use of bank nurses, and both areas of employment continue to grow (Buchan and Seccombe, 2004).

## **QUESTIONING THE ACCEPTED PICTURE**

### **UNRELIABLE STATISTICS**

Thus far I have described the situation of British nursing as it is portrayed in governmental and professional publications and in the media. The data offered appears to show that there has been a clear problem as high levels of wastage and inadequate levels of recruitment contributed to a national shortage of nurses during the late 1990s and early 2000s. However, nursing shortages, wastage and turnover are highly politicised issues and the statistics upon which many claims are based are often not as clear and reliable as they are presented to be. Indeed, workforce planning has been described as 'assumption driven rather than evidence based' (Buchan and Seccombe, 2002: 7). In this section I argue that our current understanding of the nursing workforce is limited by the lack of reliable, comprehensive statistical data and a lack of clarity in the use of the terminology describing trends within the workforce. Consequently, when conducting research in this area it is necessary to approach all claims with caution and to question the nature of the statistical data on which they are based.

The first issue lies with the absence of any central collection of statistics describing the actual size and composition of the nursing workforce, or the movements of nurses within and beyond nursing. Prior to the NHS reforms of the 1990s, there



was no centralised collection of NHS workforce statistics, and the only available data was collated from statistics gathered at the local level. Buchan and Seccombe claim that, since the 1990s, the quality of data available for workforce planners has eroded further (ibid.: 6). The decentralisation of the NHS into a large number of autonomous Trusts, each making its own decisions regarding the nature and form of the data to be collected, has rendered the task of collating NHS data to produce a national picture exceedingly difficult (Buchan, 2000a: 321). The problems that the lack of a co-ordinated national database creates are apparent in the caveats applied to official statistical reports which state that the information given must be treated with caution as it is based only on the figures available from organisations that submitted data (e.g. DoH, 1999; ISD Scotland, 2005<sup>8</sup>). Since devolution in 1999, the difficulties involved in analysing the nursing workforce have intensified with each of the four countries of the UK developing its health services in different directions. A recent study reports that the varying approaches to collecting data have created a situation in which it is impossible to make meaningful comparisons across the UK (Kings Fund, 2005).

In the absence of reliable data from the NHS, most of the claims regarding the size of the nursing workforce draw on the register of nurses maintained by the NMC, a source that contains several fundamental flaws when used in this way. For example, the register records those who are fit to practice but does not indicate how many registered nurses are practising. Since a nurse only renews her registration once every three years, many people who are currently on the register will have retired, taken a break from practice, left nursing or even died. Furthermore, double counting further clouds the numbers since a nurse can be registered under several different specialities. Thus, any figure relating to the number of nurses available for work has to be calculated on the basis of a series of assumptions. Although the NMC register has been used to indicate the number of nurses 'leaving' each year, the inaccurate nature of the figures, for the reasons described above means that:

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<sup>8</sup> In Scotland the response rate for workforce statistics has risen from 78% in 1996 to 97% in 2002 and has achieved 100% each year since 2003 (ISD Scotland, 2005). However, the reliance on Trusts' co-operation for accurate figures means that this caveat continues to be applied.

Little is known about why people fail to renew their registration or the relative importance of different causes (death, ill health, retirement, emigration etc). (Buchan and Seccombe, 2002: 21)

Consequently, any claims made about the size of the nursing workforce, or the reasons for changing trends that are based solely on the NMC register need to be treated with caution.

At present, there is a move towards the introduction of integrated workforce planning with the recent creation of national databases (Scottish Executive, 2000; DoH, 2000). In England, the DoH has introduced Workforce Development Confederations, bringing together NHS and other healthcare employers in order to provide coherent information for central planning (Buchan and Seccombe, 2002). In Northern Ireland a census of NHS staff has been conducted for the years 2001 to 2004<sup>9</sup> (DHSSPSNI, 2002, 2004). However, it will be several years before there will be sufficient reliable data to provide a clear picture of the trends within the nursing workforce across the UK and, unless there is a move to harmonise data collection, comparisons between countries will continue to be problematic. Until the new national databases have collected sufficient data to demonstrate the changing trends over several years, very little can be said with certainty about the size or composition of the nursing workforce, or of nurses' movements into and out of work. Until then Maynard's comment, made in 1994, holds true:

The most remarkable thing about the supply of nurses and the demand for them is how little is known about it. (Maynard, 1994, cited by Soothill et al. 1996: 282)

As the conflicting positions regarding the existence of a current nursing shortage presented above indicate, the lack of reliable information has not reduced the strength of the claims made in the debates surrounding nursing shortages. Competing interest groups continue to present statistics that appear to support their particular agenda. The conflict between Government and nursing accounts of the nursing shortage revolves, in large part, around conflicting definitions of what constitutes a shortage. The Government focuses on numbers of staff at the national level while nurses' tend to refer to localised shortages in geographical areas or

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<sup>9</sup> The Northern Irish census records the size of the workforce as well as turnover, vacancies and the numbers of staff leaving the NHS in the region. However, it does not make clear whether these staff are leaving nursing or are moving to other parts of the UK.

particular specialisms. In their report for the RCN, Buchan and Seccombe highlight this difference, criticising the Government's target figures on the grounds that there is no indication of the skills that the new nurses will require, or how they are to be deployed (Buchan and Seccombe, 2002). The varying definitions of shortages that lie at the centre of this dispute point to the second source of confusion that clouds our understanding of nursing workforce issues. That is, the lack of clarity in the conceptualisation of key terms such as shortage, wastage and turnover.

## **INADEQUATE CONCEPTUALISATION OF TERMS**

### **What Constitutes a Shortage?**

The question 'what constitutes a shortage?' lies at the heart of a highly political debate. Buchan states that the official government definition of a shortage, i.e. that there should be problems in all specialities in all locations, means that there has never actually been a shortage of nurses (Buchan, 1997). Until the most recent crisis, this position has suited governments who fear that, by acknowledging a national shortage, they could strengthen the unions' demands for wage increases (ibid.). This is of particular importance to ministers since the nursing pay bill comprises approximately 3% of all public sector expenditure (Buchan and Seccombe, 2002: 1) and constraining nurses' pay has been an obvious means of limiting health expenditure for successive governments (Buchan, 2000a). The longstanding absence of a national database can also be seen as reflecting this fear of rising pay bills, since a lack of national statistics has enabled past governments to deny shortages on the grounds that there was a lack of evidence (ibid.). The political significance of a centralised collection of workforce data is illustrated in the decision, made by the Conservative Government in 1996, to end the collection of national data pertaining to the professions allied to medicine (PAMs). The Government argued that there was no strong justification for collecting this data, while the Chartered Society of Physiotherapists (CSP) argued that the decision indicated the Government's unwillingness to recognise high turnover (Chadda, 1996). The timing of this decision, prior to the 1997 General Election that swept the Labour Party into office, may simply be a coincidence, but it may also have

reflected a desire to remove the ammunition provided by figures indicating high levels of turnover among PAMs, at a time when the NHS was a key election issue.

Although attitudes towards a national database have changed across the UK since devolution, the continuing absence of reliable figures indicating how many nurses are available to work is compounded by a lack of agreement as to how many are needed. Since there is no single method by which establishment figures are set, it is difficult to establish with clarity the number of nurses needed at the national or local level, or the balance of skills required within the workforce. The setting of establishment figures involves the power to allocate resources and as such it is not simply a matter of performing a straightforward calculation but is a highly political issue with competing interest groups vying for the authority to control resources. The dramatic increase in the demand for nursing care has posed problems both in terms of the limited number of nurses available to fill posts and the implications of funding sufficient posts. The debate over nursing shortages reflects these tensions as nurses argue the need for increases in staffing levels while employers seek to balance the need for new posts with the constraints posed by their budgets. Christine Hancock, General Secretary of the RCN until 2001, argued that a universal tool for determining staffing levels would be a 'blunt instrument since departments differ in size and layout.' (Hancock, 2000: 13). She claimed that the most reliable calculator of establishment figures is an experienced charge nurse (ibid.: 14). This position challenges the present balance of power in which staffing levels are determined by managers, usually on the grounds of the available funding (Vousden, 1988), and nurses are not generally included in the decision making process. However, in a significant change to the usual exclusion of nurses from decision-making in this area, in 2003 a senior nurse was seconded to the Scottish Executive to lead a project charged with developing national mandatory standards for staffing levels (*Nursing Times*, 2003a). This may be a sign of change but, in general, nurses' inclusion in such important decision making processes is minimal.

The implications of nursing's failure to influence staffing levels are apparent in the claims made by many nurses that their wards are understaffed, even when there are no posts vacant. For example, Williams et al note that a revision of establishment figures in one Health Authority led to a situation in which nurses complained of being short staffed when, according to their managers, there was no official

shortage (Williams et al, 1991). The conflict between professional and managerial views regarding staffing levels is also illustrated in the experiences of the Belgian healthcare system. Despite introducing a national tool to set establishment figures, based on calculations of nursing workload, quality and resources, Belgian nurses still went on strike to demand more staff (Williams, 2000).

At the heart of this dispute lie opposing views on the number of nurses needed to fulfil a given workload and on whether quality of care or financial considerations should be given priority. Mackay comments on the use of 'tight staffing levels' suggesting that staffing levels are kept deliberately low rather than being the product of a shortage in the supply of staff (1989). This practice is alluded to in the suggestion that vacancies statistics are an unreliable indicator of nursing shortages since some Trusts hold posts vacant for a period of time in order to make savings on the costs of employment (Soothill et al, 1996; White, 2002). The criteria for vacancies counted in the statistics allow for this possibility since only those that have been open for three months and which Trusts are 'actively trying to fill' are included (DoH, 2004c; ISD Scotland, 2005).

However, in an apparent twist in the tendency for managers and policy makers to advocate 'tight staffing levels', the Government recently circulated a DoH report to all Human Resources departments in the NHS. This document suggests that,

Wherever possible, increase staffing levels or reorganise work in order to increase opportunities for staff to give patients more personalised care (DoH, 2003: 357)

This recommendation reflects the authors' recognition that staffing shortages and the consequent loss of patient contact time are a crucial element of nurses' dissatisfaction. As such it indicates a shift towards the position taken by nurses, although the power of decision-making regarding staffing levels remains with managers rather than nurses and the practical impact of this document remains to be seen.

### **Distinguishing Between Wastage and Turnover**

The lack of clarity surrounding the language of shortages is also seen in that of wastage and turnover which often confuses a range of very different phenomena. Nursing has always experienced relatively high levels of turnover as people move

on from one job to another, and the RCN claims that the level across the UK has increased year on year since 1998 when it stood at 18% (Ball and Pike, 2004). However, the lack of reliable data on the destinations of leavers means that the proportion of turnover that can be described as wastage, or a loss of the individual concerned, is unclear.

In part, the high level of turnover within nursing is due to the predominance of women in its ranks, and the impact of childbearing and rearing on their career patterns. The 2002 RCN membership survey reports that 55% of respondents had childcare responsibilities, 16% had adult dependants and 9% carried both responsibilities (RCN, 2003e: 16). Nurses who are mothers will at least take a short break from practice around the time of their children's births. In 1993, Seccombe claimed that half of all NHS nurses had taken a career break at some point (Seccombe, 1993), a figure that seems unlikely to have changed significantly in the past ten years.

A significant level of turnover is also built into nursing since new nurses are expected to move between posts in order to 'consolidate' their training in a variety of settings. Further turnover is created by the need for nurses to apply for a new job in order to move to a higher grade.<sup>10</sup> Melia suggests that turnover may also be increased by students who carry the itinerant patterns of student life into their careers as qualified nurses (Melia, 1987). Low levels of turnover are widely seen as an indicator of good practice (Buchan and Seccombe, 2002), indicating high levels of satisfaction among staff. However, low levels can also be seen as problematic on the grounds that staff become stale if they remain in post for too long (Hockey, 1976; Redfern, 1978; Gray and Normand, 1990), or that the opportunities for promotion are reduced (Soothill et al, 1996). The lack of agreement surrounding the desirable level of turnover means that statistics in this area need to be viewed with caution as simple numerical descriptors rather than as indicators of clear positive or negative trends.

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<sup>10</sup> Grades for registered nurses begin at D with junior staff nurses, and rise through E and F grade senior staff nurses, to G grade charge nurses or specialist nurses. H and I grade nurses are generally found in managerial posts. This system of grading is currently being replaced by a national framework of grades in 'Agenda for Change'. The new four-tier system will comprise healthcare assistant (HCA), registered practitioner, senior registered practitioner, and consultant practitioner. Progression will depend upon a competency framework (Buchan, 2000d and 2000e).

In addition to the lack of agreement surrounding the acceptable level of turnover, the relationship between turnover and wastage is also unclear since, as Grocott notes, the term 'turnover' can be applied at different levels to describe movement between wards, within the same hospital, in and out of the NHS or even in and out of nursing itself (Grocott, 1989). At the district or regional level, turnover between Trusts may be viewed as wastage by hospital or regional managers, but those nurses concerned have not been lost to the NHS (*ibid.*). While Grocott defines wastage as the loss of staff from the NHS, Soothill et al apply the term to the costs incurred to the NHS by a high level of turnover at all levels (Soothill et al, 1996). In this case, the cost to Trusts of recruiting and training replacement staff is ultimately paid for from the NHS budget.

The confusion surrounding the terms 'wastage' and 'turnover' is reflected in the broad usage of the term 'leaver' to describe those who are contemplating leaving, those leaving one post for another, those who are taking a temporary break and those who have moved on to new areas of employment. The existing statistical data about nurses' movements often fails to indicate whether any breaks in practice are temporary or permanent. Williams et al point to the danger of subsuming all 'leavers' in one category in this way, claiming that only 22% of those 'leavers' they interviewed saw their exit from nursing as permanent (Williams et al, 1991: 21). In 2001 Gage et al found a similar percentage of permanent leavers, while 60% said they were unsure about returning (Gage et al, 2001: 2). In these cases, a nurse who has left nursing may not know herself whether her absence from practice marks a career break or a complete and final move away from nursing.

In some studies too these groups of leavers are not clearly separated, leading to confusion regarding the nature of the trends described. For example, Mackay interviewed fifty 'leavers' but this group included nurses who were moving on to new NHS posts, or to undertake further training, as well as those who were leaving nursing completely (Mackay, 1989). Although Gage et al (2001) begin by breaking down their 'leavers' into more clearly defined groups, their subsequent claims about 'leavers' do not clarify whether they are referring to the whole group or to its subdivisions. Thus, when nurses are described as 'leavers' it is important to ask what the author means by that term. Any claims regarding nurses leaving have to

be treated with caution. The question must be asked: What are they leaving and why?

This imprecise terminology, combined with of a lack of clear statistical data, allows sweeping claims to be made that have little basis in evidence, as Buchan notes:

The oft heard statistic that 30,000 nurses are 'leaving the profession' every year is misleading, suggesting as it does the end of a career, rather than a break in a career. (Buchan, 1992: 46)

The assumption that nurses who express a desire to leave nursing will actually do so is also problematic since there is no clear evidence that this is the case. Although Soothill et al (1992) report that 77% of nurses who stated in a questionnaire that they intended to leave acted on this statement within three years, their study identifies 'leavers' as nurses planning to leave their Health Authority rather than nursing. Furthermore, the tendency to act upon the intention to leave relates to a stated intention rather than the general desire to leave reflected in the surveys cited above. Soothill et al report that the behaviour of those nurses who answered that there was a 'slight chance' or 'no chance' of them leaving or who were 'uncertain' was not consistent enough to provide any useful guide for planning purposes (ibid.). Their study therefore provides no support for the assumption that surveys indicating a widespread desire to leave among nurses are indicative of either an imminent or an actual mass exodus. Indeed, the authors comment on the overwhelming propensity for nurses to stay (ibid.: 174).

Until the problems surrounding the lack of reliable statistics and of consistent conceptualisation are addressed, it is difficult to make any claims about the size of the nursing workforce or of the movements of nurses within it. In particular, the lack of reliable figures describing the nursing workforce means that claims of an ongoing exodus from nursing need to be seen as part of the common-sense understanding of the NHS that provides the context for this study, rather than as a statistically proven reality.



# THE STATE OF THE NURSING WORKFORCE

## A STATISTICAL PICTURE OF AN AILING WORKFORCE

In contrast with the uncertain state of knowledge about the size and movements of the nursing workforce, the evidence regarding the internal state of NHS nursing is clear. Statistics in this area, which are grounded in studies that sample the nursing population rather than seeking to enumerate and describe it in its entirety, offer a consistent picture of a workforce that is experiencing serious problems with escalating workloads, low morale and high levels of sickness absence.

Earlier in this chapter I described how a range of factors have combined to increase the workload carried by nurses enormously. Williams et al (1998) demonstrate the impact of these increasing demands upon nurses in their claim that nursing has a high level of sickness absence compared with industry. Demerouti et al (2000: 455) claim that 25% of all nurses suffer from burnout, and Borrill et al (1998) present similarly startling figures in their study of the mental health of NHS staff, claiming that 28.5% of nurses surveyed could be classified as having minor psychiatric disorders. This figure is 40% higher than that found in comparable groups<sup>11</sup> (ibid.: 24). Hawton et al (2002) connect the psychiatric problems experienced by nurses to their finding that nurses have a higher risk of suicide than the general population. These figures help us to understand those cited earlier in the chapter which indicate that a large proportion of nurses would leave their chosen profession if they could. They also provide some explanation of the escalation in the use of expensive agency nurses across the NHS. High levels of physical and mental illness, coinciding with a large number of vacant posts, have contributed to the huge increase in spending on agency staff described above. In chapter three I show how this increase in temporary staff adds to the pressure on those in permanent posts.

Although there is not sufficient reliable statistical evidence to support the claim that a mass exodus of nurses is currently underway, this evidence of serious problems

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<sup>11</sup> These problems are not exclusive to the UK. For example, a comparative study of nurses in England, Scotland, the USA, Canada and Germany found that American nurses are three to four times more likely to be unhappy in their work than the average worker, and 'a significant proportion' of nurses in all of these countries, excepting Germany, had high scores for burnout (Aitken et al, 2001). South African nurses also list similar grievances to their British colleagues, complaining of being unable to utilise their skills, being overworked, and having no time for the individual needs of patients (Deane, 2003). These studies suggest that high levels of sickness and low morale within the NHS are part of a far wider problem affecting nurses across the world.

within the nursing workforce has placed the issue of nursing shortages high on the agenda of both policy makers and researchers. In the following section I explore the research that has been conducted in this area that seeks to understand the factors that underpin the widespread desire among nurses to leave nursing. This research falls into two main groups; that which focuses on identifying nurses' grievances as targets for intervention, and that which focuses on the nature of nurses attitudes and behaviour with respect to leaving.

## RESEARCHING NURSES' GRIEVANCES

This body of research comprises a large number of studies stretching back over many decades that have sought to identify the key sources of nurses' dissatisfaction. Although the results have provided guidance for a series of interventions at both the government and professional level, these interventions appear to have been largely unsuccessful since the same grievances have been identified repeatedly over a period of thirty years, as table one demonstrates.

Table One: Research into the Sources of Nurses' Dissatisfaction, 1976-2005

<i>Source of Dissatisfaction</i>	<b>Examples of Research Citing Source of Dissatisfaction</b>
Inadequate pay.	Hockey, 1976 Mackay, 1989 Williams et al, 1991 Soothill et al, 1996 Vousden, 1998 RCN, 1998 RCN, 1999b Meadows et al, 2000 Ball and Stock, 2000 DoH, 2003 Ball and Pike, 2004 RCN, 2005c

<i>Source of Dissatisfaction</i>	<b>Examples of Research Citing Source of Dissatisfaction</b>
Inadequate resources and staffing, leading to nurses' inability to provide care to the standard they expect of themselves, or to use their skills to the full.	Hockey, 1976 Price Waterhouse, 1988 Mackay, 1989 Williams et al, 1991 Moore, 1992 Soothill et al, 1996 Vousden, 1998 RCN, 1999a Meadows et al, 2000 Wheeler et al, 2000 Callaghan, 2003 DoH, 2003 Ball and Pike, 2004 Scottish Executive, 2004
Excessively heavy workloads.	IMS, 1987, cited by Vousden, 1988 Mackay, 1989 Soothill et al, 1996 UNISON, 1997 RCN, 1998 RCN, 1999b DoH, 2003 Ball and Pike, 2004 Scottish Executive, 2004b RCN, 2005c
A lack of flexibility in working patterns.	Soothill et al, 1996 Vousden, 1998 RCN, 1999b Meadows et al, 2000 DoH, 2003 RCN, 2005c

<i>Source of Dissatisfaction</i>	<b>Examples of Research Citing Source of Dissatisfaction</b>
Inadequate provision of childcare facilities.	Hockey, 1976 Mackay, 1989 Williams et al, 1991 Soothill et al, 1996 Vousden, 1998 RCN, 1999b Meadows et al, 2000 DoH, 2003 RCN, 2005c
A lack of opportunities for personal and professional development.	Hockey, 1976 Williams et al, 1991 Soothill et al, 1996 RCN, 1998 Meadows et al, 2000 Wheeler, et al, 2000 Audit Commission, 2001 Callaghan, 2003 DoH, 2003 Ball and Pike, 2004 Scottish Executive, 2004b
The low status of nurses.	Mackay, 1989 Williams et al, 1991 Soothill et al, 1996 Vousden, 1998 Meadows et al, 2000 Ball and Pike, 2004
Low morale among nurses	Mackay, 1989 Moore, 1992 Ackroyd, 1993 Soothill et al, 1996 Vousden, 1998 Callaghan, 2003

Although the results of these studies are clear and consistent, the question remains, why have levels of dissatisfaction remained high over the past few decades if the sources of discontent are as well documented as they appear to be?

One possible answer relates to the source of the data on which the research seeking to explain why nurses leave is based. Williams et al (1991) interviewed people identified in Health Authority records as leavers and found that the reasons for leaving stated in the official records were:

wildly discrepant and did not tally with what the individual told the research team. (Williams et al, 1991: 21)

Since the Health Authority in question did not conduct exit interviews (*ibid.*), one has to ask: from where did they obtain their information? Soothill et al (1996) place the blame for such discrepancies on nurses, describing a tendency for nurses to 'gild the lily', changing their accounts according to whom they are talking to, and giving different versions in official and unofficial settings (*ibid.*: 275). This rather pejorative metaphor, seems to suggest a belief that, in offering different versions of a story, nurses are not being truthful. However, there are many different levels of truth, and nurses, as human beings, may fear the consequences of speaking their minds without reservation, choosing the safer option of giving a simple, non-confrontational explanation of their decision to leave. It is for precisely this reason that Williams et al (1991) call for exit interviews to be conducted by independent teams. They claim that many of their respondents hid behind simple but truthful explanations for leaving such as marriage, having a baby, embarking upon further training, or ill health (Williams et al, 1991).

An alternative answer is offered by Mackay and others for whom the problem lies not in failings within the data but in the lack of any serious policy intervention. Mackay argues that this stems from a belief among policy makers that nurses are relatively cheap and easy to replace (Mackay, 1998). This claim echoes Davies' suggestion that high turnover among nurses is accepted as an inevitable aspect of a predominantly female workforce, leading to the perception that nurses are disposable (Davies, 1995). Meadows et al make a similar claim, arguing that nurses' loyalty to the NHS has allowed levels of concern, and therefore of intervention in this area to remain relatively low (Meadows et al, 2000). In effect they argue that not enough nurses have left the NHS to force their grievances onto the agenda. This seems an unlikely explanation given that, in addition to the policy responses that I describe above, Government interventions pre-date the latest shortage. For example, in the early 1990s, the Government gave its backing to internal nursing reforms that sought to address issues of personal and professional development.

These include the introduction of the Post Registration Education and Practice Scheme (PREP) in 1992<sup>12</sup> and the move of nurse training into the higher education sector in 1992 with Project 2000. However, some support for the claims that a lack of intervention lies at the root of at least one of these grievances can be found in the area of pay. The enormous size of the nursing workforce creates a tension between the demands of nurses for higher pay and more staff, and the financial implications of significant improvements across the board. This creates a situation in which pay increases are often staggered or targeted at particular grades, diluting their impact and creating further resentment as I describe in chapter four.

Despite all the Government's policy initiatives, there has been little corresponding change in the list of nurses' grievances. Buchan attributes this to the way in which many of the policies designed to address nursing shortages have not been properly implemented or evaluated, leading to cycles of shortages in which the same policies are repeated with similar poor levels of success (Buchan, 1998). He argues that, rather than reflecting the success of Government policy, the previous shortage in the mid 1980s was arguably resolved by a downturn in the economy that pushed many women back into employment in order to sustain the family income (Buchan, 1992). Buchan's argument highlights the need to consider the wide range of factors that comprise the cultural and economic context within which a policy is introduced as well as the nature of the policy itself. Nurses and their leaders may choose to accept and co-operate with, or to undermine, new policies and structures introduced by government (Beil-Hildebrand, 2004), while changes introduced by nursing bodies may stand or fall in response to the support given to them by government agencies and other interested parties.

Although the body of research evidence identifying discrete sources of dissatisfaction provides a clear list of grievances, the lack of success in addressing these issues indicates that this approach to understanding nurses' dissatisfaction and its links to wastage and turnover is apparently not sufficient in itself. One element in the failure of this approach to solving problems of high wastage and low

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<sup>12</sup> PREP was introduced to ensure that nurses continue to learn throughout their careers, updating their knowledge and skills on a regular basis. The NMC requires each nurse to keep a record of her learning. Nurses are also required to re-register every five years, and may be required to produce this record as evidence of their continuing professional development.

morale seems to be that it seeks simple solutions to what are often complex problems. Soothill et al (1996) note that in their research no single reason for dissatisfaction stands out as more important than the others. Instead, the desire to leave represents the cumulative effect of a range of factors that fuel nurses' dissatisfaction. This point is also made by Meadows et al (2000) who suggest that, rather than resulting from a single cataclysmic event or overriding factor, the decision to leave is often a response to a relatively minor event which follows a long period of dissatisfaction. This perspective indicates a complex interplay of factors in which the 'reasons' for leaving identified in exit interviews and research studies may represent the proverbial straw that broke the camel's back rather than fundamental causal factors (ibid.). In contrast with this focus on identifying and targeting key grievances, other researchers have turned their attention to the people experiencing and responding to these problems. This second body of research examines nurses' orientation towards their work with the aim of identifying predictive factors that will indicate which nurses will respond to their dissatisfaction by leaving. Categorising practising nurses into 'stayers' and 'leavers' according to these factors is then expected to give some indication of the extent of the potential exodus.

### **RESEARCHING NURSES' ORIENTATION TO WORK**

In contrast with the way in which much of the research in this area focuses on the causes of nurses' dissatisfaction, a number of researchers have turned their attention to the personal characteristics of nurses themselves. They seek to develop sociological categories of 'leavers' and 'stayers' which offer some possibility of predicting which nurses are likely to continue nursing and which will leave in response to dissatisfaction (e.g. Birch, 1975; Mackay, 1989; Soothill et al, 1996; Gage et al, 2001; Kotecha, 2002). The proportion of leavers and stayers is seen as indicative of both the current and prospective extent of the exodus from nursing.

### **Personality As A Predictor Of Leaving/Staying**

An early attempt to describe the differences between stayers and leavers was conducted by Birch (1975) as part of an investigation into the causes of withdrawal during nurse training. Birch focused on student nurses' personalities, applying a battery of personality tests to the two groups. He concluded that stayers were more

insecure and timid, demonstrating a proneness to guilt, while leavers were higher in motivation but lower in self-control, persistence, foresight and consideration for others (ibid.). For Birch, the answers lay in improving nurses' ability to cope rather than in tackling the sources of their dissatisfaction. He recommended improvements in the support available to nurses as well as the use of personality tests in recruitment. This would ensure that only those people with the necessary characteristics to cope with the stress of nursing were offered training (ibid.). Birch's description resonates with the more recent finding that those students who leave tend to be the more confident ones who cannot, or will not, adjust their initial expectations of nursing, while stayers tend to be more pliant and open to adapting to their circumstances (Kotecha, 2002).

These studies offer limited possibilities for understanding the nursing workforce since they both concern students rather than qualified staff. The latter group have, by definition, been through a longer period of socialisation and have passed through the initial probationary period during which people judge whether or not they are likely to be satisfied with their choice of career. The usefulness of these findings is also limited by the lack of consistency in the personal traits studied which at times leads to contradictory conclusions. For example, Cowin (2001) argues that it is the leavers rather than stayers who are characterised by low self-esteem and self-confidence. The variations in the definitions of 'leaver' and 'stayer' used, which I identify earlier in this chapter, also contribute to confusion and difficulty in establishing a clear picture of the workforce from this body of evidence.

### **Socio-Economic Characteristics As Predictors Of Leaving/Staying**

Problems also arise with the work that seeks to categorise leavers and stayers according to their socio-economic characteristics. For example, Gage et al (2001) used data from the British Household Survey to identify and survey leavers and stayers in both nursing and teaching. They concluded that nurses who leave tend to be older and to work longer hours than stayers; they are less likely to be homeowners and to have a second job. No differences were found with respect to gender, marital status, dependant children or overtime. From this Gage et al concluded that the main characteristics shaping nurses' decision to leave relate to their family responsibilities. The inference seems to be that nurses with mortgages,



or who need to bring in multiple incomes for other reasons, are less free to act on their desire to leave than those in more favourable economic positions. While this study demonstrates broad correlations between socio-economic factors and whether or not nurses are currently practicing, the large scale, survey approach is unable to offer a detailed account of the rational and emotional factors that one might expect to interact with socio-economic factors to shape nurses decisions.

### **Commitment As A Predictor Of Leaving/Staying**

The work that I have cited thus far is based in the assumption that nurses are leaving in large numbers. For those that study student attrition this assumption has some basis in statistical evidence. However, some researchers question the existence of an exodus among qualified nurses. For example, in her description of the problems that nurses face, Mackay (1989) offered a vivid description of the commitment to nursing that many of her participants felt and contrasted this with the frequency with which they discussed their desire to leave. Mackay repeated the findings of other researchers in her claim that most of nurses' discontent centres on problems of understaffing and a feeling that they cannot do the job they love well (ibid.). Williams et al (1991) also reported this phenomenon, summarising it in the title 'Love Nursing, Hate the Job'. In the light of this tension, Mackay (1989) questioned the existence of an exodus and argued that more nurses ought to have been leaving than actually were. She turned the usual quest for reasons why nurses leave around, asking instead: If nurses are so dissatisfied, why do they stay? (ibid.). This question leads on to another area of research in this area, namely the presence or absence of nurses' commitment to their work, the nature of this commitment and the role that it plays in their responses to dissatisfaction.

The central role that commitment plays in nurses' decisions to stay or leave is widely recognised but, as yet, poorly understood. In many cases, references to this important concept reflect common-sense assumptions rather than understanding based in research. Nurses' commitment, or their lack of it, is often cited as the key explanatory factor for nursing shortages. For example, Dingwall and Allen (2001) associate a loss of 'professional commitment' with the decision to 'drop out'. Former RCN Scottish Secretary June Andrews connects the survival of a sense of commitment with staying in her claim that:

It is nurses' commitment to patients that keeps them at the bedside and in the community. However, ... nurses' commitment is under severe strain. (RCN, 1998)

Andrews' assumption of the continuing existence of commitment among nurses also appears in research papers. For example, Gage et al (2001) draw on the concept of a vocational commitment to nursing in order to explain why nurses are less likely to respond to dissatisfaction by leaving than teachers. This is a speculative explanation for the trends observed since a vocational commitment is not one of the factors analysed within their study. Similarly, although Mackay does study nurses' commitment, her claim that a sense of vocational commitment holds people within nursing lacks any basis in evidence since only 18% of her participants apply the specific term vocation to themselves (Mackay, 1998: 52). Furthermore the concept of commitment is not included as part of her analysis of participants' reasons for staying or leaving.

In 1978 Altschul commented on the lack of research into the nature of nurses' commitment and, despite the central importance of this concept to the issue of leaving nursing, few studies have been conducted since that relate commitment to leaving or staying. This gap in the literature both undermines our understanding of leaving nursing and creates problems for nurses who may be unfairly criticised for lacking commitment, or offered patronising platitudes for demonstrating a strong commitment in the face of enormous pressure. As Meadows et al argue:

the commitment to care that nurses bring, because it is not at all well articulated or understood and because it is simultaneously romanticised and trivialised by others, can serve to lock nurses into a spiral of resentment and cut them off from co-workers.

(Meadows et al, 2000: 47)

However, despite the dearth of research in this area, a small number of studies have sought to describe and explain the nature of nurses' commitment to their work and the part that it plays in whether a nurse chooses to leave or to stay in nursing.

Some support for the idea that commitment lies at the heart of nurses' decision making is provided by Duffield et al (2004) who claim that a longer tenure in nursing is associated with an altruistic motivation for entering nursing and a strong emphasis on professional values over the need for a work/life balance. However, this study too lacks a detailed account of the form of subjects' commitment and the way in which it shapes their decisions.

Duffield et al's reference to professional values points to one way in which nurses' commitment has been conceptualised in the literature. In this case the term 'professional values' is used according to common parlance to describe the common occupational values of nurses. However, other writers use the term in more specific, sociological terms, dividing nurses into the binary categories of 'vocationalizers' and 'professionalizers' (Habenstein and Christ, 1955; Mackay, 1998; Melia, 1987; Booth et al, 1990). The former are described as placing emphasis on the importance of commitment to patients, caring, communication and the innate qualities of a nurse, and the latter as emphasising the importance of raising the status of nursing through technology, knowledge and skill.

This binary view of commitment was adopted by Mackay (1989) who claimed that nursing in the late 1980s was characterised by a strong vocational orientation. She predicted an imminent exodus from the profession as a consequence of the rise of this alternative professional orientation (ibid.). Those with a vocational orientation were assumed to have a strong commitment to their work with patients that motivated them to persevere whatever their circumstances. Professionalizers' motivation was seen as lying in career progression and in enhancing the status of nursing, resulting in a greater willingness to leave in search of more rewarding work when they experienced dissatisfaction. On returning to this work in the late 1990s Mackay asked why the predicted exodus had not occurred (Mackay, 1998) but, rather than questioning the validity of her categories, she argued that the exodus was delayed by the slower than expected growth of the professional orientation within nursing (ibid.).

An alternative explanation for the failure of Mackay's prediction lies in the possibility that nurses' commitment to their work, and therefore their willingness to consider leaving, is a more complex phenomenon than this binary categorisation suggests. Thus far, staying and leaving have been described in relatively simple terms, with stayers' commitment motivating them to continue nursing when they experience dissatisfaction. Leavers are categorised as those whose lack of commitment has either already prompted them to leave or who are likely to do so in the immediate future. Leaving is treated as if it is a sudden, deliberate and irrevocable choice. The difficulties involved in dividing nurses in this way are

noted by Williams et al (1991) who claim that many of their subjects do not see their decision to leave as final. The same point is also made by Soothill et al (1991).

The problems in using these binary categories of nurses' commitment led to a study conducted by Peelo et al (1996) in which a more detailed categorisation of nurses' commitment was sought. The four groups described in table two were identified on the basis of a series of questionnaires exploring issues of commitment, career, salary and absenteeism. These categories show more clearly the variation in both nurses' tendency to identify problems at work and their willingness to continue nursing when problems arise.

**Table Two: Categories of Commitment To Nursing Developed by Peelo et al (1996)**

Category Of Commitment	Characteristics
1 - Nursing Come What May	These nurses identify the fewest problems in their working lives and make the fewest demands. Nursing is their life whatever happens and they will not leave. This group contains a high proportion of community nurses but the reasons for this are not clear.
2 - Nursing But For How Much Longer?	Nurses in this group show high levels of disillusionment and are more likely than group one to cite practical incentives for leaving.
3 - Nursing, Battling It Out	These nurses are 'stayers' but are concerned about their situation within nursing. They cite more problems than group 1 and find their work unrewarding. A high proportion is combining childrearing with work.
4 - Nursing, 'Just A Job'	These nurses are more likely than other groups to respond to external factors by leaving e.g. when having a baby. Their dissatisfaction centres on levels of pay rather than on problems with career progression.

Peelo et al note that nurses may move between these groups over time, particularly in response to situational factors such as family commitments. This may explain why groups one and three contain more older nurses, and why group four has the highest proportion of under 25s and students. However, this study does not clarify whether these variations in age composition represent changes in individual nurses' commitment over time, or differences between succeeding generations of nurses. However, in identifying the variations in nurses' age and situation between groups, Peelo et al point to the next step in understanding nurses' commitment. That is the

importance of situating nurses' personal characteristics within some sort of context. In this they cite Ackroyd's comment that in order to understand the relationship between emotion and behaviour one needs a wider theoretical construction allowing for the complexities of situation and feelings (Ackroyd 1993). Ackroyd argues that such an approach would facilitate the development of deeper insights into nurses' attachments to their work than have been developed thus far (ibid.). In the following section I argue that this study responds to Ackroyd's arguments in combining the specific grievances and forms of commitment described in previous work with an analysis of individual nurses' accounts of their working lives, and connecting the details of individual accounts with the broader political economy of nursing in the British NHS.

## **BUILDING ON THE EXISTING RESEARCH**

In this chapter I describe our current understanding of the state of the NHS nursing workforce from both a common-sense and a research perspective. I argue that, while there is a general consensus that all is not well within NHS nursing, the nature and scope of the problems faced, and consequently the necessary remedies, are contested and unclear. Attempts to define the issues statistically are limited by problems of conceptualisation and the lack of a comprehensive national database covering all four countries of the UK. Although we have a clear and consistent list of the grievances that lie behind high levels of dissatisfaction among nurses, this approach has not apparently led to demonstrably successful policy interventions. This lack of progress may reflect the way in which the explanations produced tend to be taken in isolation from each other and are seen in static terms that ignore the dynamism of nurses' work and lives. Each individual explanation is given too much analytical weight but tends to remain under-developed in conceptual terms. Too much emphasis is placed on what can be understood by and changed within the policy process and there is a lack of grounding in a real insight into nurses' individual perceptions, motivations and possibilities for career change. These studies lack a detailed grounding in the wider discourses of nursing and do not address adequately the ways in which the overall culture of work in Britain shapes the problem and limits possible solutions.

The body of research seeking a better understanding of nurses' orientation to their work goes some way to answering this lack of grounding and indicates that the concept of commitment is a central factor in shaping nurses' responses to dissatisfaction. However, by seeking to generate single, authoritative accounts of individual nurses' motivations and actions, these studies tend to mask the dynamism and conflicting rationales inherent in individual pathways of staying and leaving. The search for predictive categories requires a simplification of the data that precludes a detailed, contextualised understanding of the nature of nurses' commitment and its specific role in shaping their decisions.

This study seeks to address these issues by combining the insights provided by the research described above with an analysis of individual nurses' accounts of their working lives. I contextualise both sources of material within the broader political economy of British nursing and in so doing produce a picture of the British nursing

workforce that illuminates both individual nurses' thoughts and experiences and the trends that their combined behaviours produce.

In contrast with previous studies, which have sought to establish linear, causal relationships between nurses' attitudes and their behaviour, my perspective is holistic and hermeneutic. I attempt to demonstrate how a wide range of factors interconnect to influence the ways in which nurses understand, feel about, and respond to nursing. I seek to paint a broad picture of what it is like to be a nurse in the NHS today. I describe nurses' understanding of their working role, their aspirations and expectations of themselves and each other and the ways in which these perspectives reflect or come into conflict with the dominant discourse of nursing. I give a breadth of perspective to this picture by situating nursing discourse and structures within their social, economic and political context. I also give it depth by exploring the historical context that has shaped the experiences and perspectives of nurses today. In so doing I hope to paint a picture of nursing that provides a background to the existing research in this area, connecting the many observations that have been made by other researchers, and adding a depth and colour to them.



## Chapter Two

# The Research Process

In chapter one I argued that the continuation of the same grievances expressed by nurses over the past fifty years is, in part, a reflection of the way in which research has focused on the need to find policy solutions, rather than on clarifying the problems that the policies are designed to address. The lack of a detailed analysis of nurses' experience and understanding of their work, as it relates to the possibility of leaving, means that, as Buchan and Secombe argue (2002), policy tends to be driven by assumption rather than by evidence. Rist (2000) argues that one of the key roles for research is to help policy makers to identify, define and understand problems as the basis for intervention. However, the pressures of limited resources, and the short term nature of the policy process, mean that attention tends to focus on previously identified problems and simple solutions that can be implemented quickly and easily (*ibid.*). Often, prompt and visible action is prioritised over long term effectiveness (*ibid.*). Rist argues the case for a stronger focus on more theoretical research that seeks to define and contextualise problems, providing policy makers with a foundation of understanding from which to consider possible interventions (*ibid.*).

The aim of this study is to contribute towards a deeper understanding of the phenomenon of leaving nursing. An understanding of why nurses may want to leave, of the meaning that this choice has for them, and of the factors that influence their perspectives and behaviour in this respect, is as important to the development of effective policy as is a sound statistical analysis of the composition and movements of the workforce.

In this chapter I begin by locating the study within its epistemological and theoretical context; identifying it as an interpretivist study set within the tradition of critical theory. I then describe the research approach that I have taken and how this shaped the methods used. I address the issues that arise in relation to studying a group of which one is a member, before moving on to describe the research process. I trace this process from the inception of the study, through the iterative process of gathering and analysing the material, to the writing of the thesis. In

laying out the decision making process I address a key aspect of validity within the interpretivist tradition: that the writer should provide the reader with enough information to enable her to judge the trustworthiness of the analysis for herself (Glaser and Strauss, 1967; Wolcott, 2002).

## **LAYING THE FOUNDATIONS**

### **THE EPISTEMOLOGICAL AND THEORETICAL CONTEXT OF THE STUDY**

This study is situated within the interpretivist research paradigm, which is rooted in the challenges posed by influential thinkers such as Kant, Dilthey and Habermas to the positivist claim that the methods of natural scientific enquiry can be applied in the study of the social world (e.g. Popper, 1972). Interpretivist research has been strongly influenced by the work of Mead and others in the symbolic interactionist tradition. They argue that the social world is not a concrete entity that exists independently from humanity and can be apprehended directly (e.g. Mead, cited by Meltzer, 1967). Rather, it is a dynamic, human construct that cannot be understood outside of the framework of language and culture in which it is daily created and recreated (Schwandt, 1994).

Everything that we experience in our lives has to be interpreted and ascribed with meaning, and the processes of interpretation and communication can only occur through the media of language and culture (Mead cited by Meltzer, 1967). These comprise the set of symbols that represent the meanings attached to objects and concepts that are agreed upon by a particular social group (ibid.). Thus:

Every single human expression represents something which is common to many and therefore part of the realm of objective mind. Every word or sentence, every gesture or form of politeness, every work of art and every historical deed are only understandable because the person expressing himself and the person who understands him are connected by something they have in common; the individual always experiences, thinks, acts, and also understands, in this common sphere. (Dilthey, 1958, cited by Outhwaite 1985: 24)

The set of shared symbols or meanings is not a static entity, but is in a constant state of flux as new meanings are developed and old ones challenged. Derrida describes

this as *differance*; that is, the meaning of any word is never absolutely fixed but is always provisional and open to various interpretations (Derrida, 1976). Furthermore, words do not exist in isolation but each carries traces of other words and their meanings (ibid.). Any interpretation has to take into account this *intertextuality*; that is, when interpreting a word or text it is necessary to consider it within the context of the other texts that give it meaning (Fairclough, 1992). The constantly evolving and shifting nature of language, and the role of context in shaping meaning, create a situation in which social research can never offer definitive answers and unproblematic facts, but only contingent interpretations (Gee, 1999; Kincheloe and McLaren, 2000). Thus, the validity of research within his paradigm rests not on whether the facts of the case have been proven, but on the plausibility of the interpretation (Glaser and Strauss, 1967; Melia, 1997), upon its usefulness (Glaser and Strauss, 1967), its trustworthiness (Gee, 1999), upon its coherence and resonance for those whose experiences it encompasses (Riessman, 1993), and upon the rigour and transparency of the research process (Glaser and Strauss, 1967; Wolcott, 2002). Since no symbolic meaning, and therefore no interpretation is definitive, the validity of an analysis also rests on its juxtaposition with earlier and later work and, therefore, its validity may change over time (Gee, 1999).

This perspective on the nature of social reality can be criticised on the grounds of relativism. However, a counter to this argument is provided by those within the tradition of critical theory. They point to the ways in which ideas become concretised in the structures and organisation of everyday life in ways that reflect the power dynamics within a society. Thus, people are neither shaped passively by the world they inhabit, nor are they free to interpret it in any way they choose (Giddens, 1984). From within this critical tradition, Gee argues that people communicate using a wide variety of symbolic forms that go beyond words (Gee, 1999). People's actions, clothes, and facial expressions, the images and structures that they create, and the rules that govern their interactions with each other all serve as symbols by which they convey meaning (ibid.). The set of symbols that represent a particular idea or phenomenon can be described as a discourse. For example, the discourse of nursing encompasses the language that describes, defines and explains nursing and that nurses use in their work, the clothes they wear, the

places in which they work, the relationships they have with others, the activities they carry out, the ways in which they behave, and the codes that delimit that behaviour. The discourse of nursing determines the expectations that people have of nurses and that nurses have of each other. It also determines the boundaries of nurses' working relationships and what is and is not seen as acceptable behaviour.

Edgar describes the complex set of possible interpretations and representations of nursing as the 'moral tradition of nursing', pointing to the way in which a discourse grows out of the set of shared meanings agreed by previous generations (Edgar, 1993). Each new generation interprets the discourse in its own way, stressing some aspects over others, adding new ideas and rejecting older ones. However, these new interpretations must be close enough to those that have preceded them to be recognisable (ibid.). A person who becomes a nurse will have her own particular perspective on what that role means, and the demands it makes of her, but her understanding and experience of being a nurse are rooted in, and limited by, this 'moral tradition of nursing' and its related discourses. She is both constituted as a nurse by the discourse of nursing, and contributes to the re-constitution of the discourse in the way that she enacts the role in her daily activities. Giddens refers to this dual relationship between the individual and the context in which she operates as the *double hermeneutic* (Giddens, 1984).

The double hermeneutic means that a discourse may change slowly as individuals reinterpret it in new ways, or it may face more radical challenges from alternative interpretations. The range of expressions of a discourse, and its dynamic and often contested nature have been summarised by Gee:

In the end, a discourse is a 'dance' that exists in the abstract as a co-ordinated pattern of words, deeds, values, beliefs, symbols, tools, objects, times, and places and in the here and now as a performance that is recognizable as just such a co-ordination. Like a dance, the performance here and now is never exactly the same. It all comes down, often, to what the 'masters of the dance' will allow to be recognized or will be forced to recognize as a possible instantiation of the dance. (Gee, 1999:19)

In his description of discourse, Gee refers to the struggle between conflicting interests over the content and form of a discourse. The concept of power is a central aspect of his 'critical discourse analysis', an approach that underpins this study and that is rooted in the work of Foucault (see Gee, 1999; Parker, 1994; Fairclough, 1992).

Foucault argues that knowledge is not a reflection of objective truth but constitutes what is accepted as truth within a society (e.g. Foucault, 1972). Consequently knowledge cannot be divorced from the power relationships that shape the processes of its production. Since discourse sets the limits of what it is possible or acceptable to do or think, as well as shaping social structures, relations and identities, it is inevitably a focus of conflict between those who wish to maintain the status quo, and those who wish to effect social or cultural change (Fairclough, 1992).

The exercise of power in the shaping of discourse operates in both overt and covert ways. Powerful groups may impose their version of reality on others using their authority, influence, coercion, manipulation or force (Lukes, 1974). However, power is most successful when it is used covertly to avoid conflict (ibid.). Foucault argues that the exercise of power:

is tolerable only on condition that it masks a substantial part of itself.  
Its success is proportional to its ability to hide its own mechanisms  
(Foucault, 1981).

One expression of this covert application of power is described by Gramsci as *hegemony* (Gramsci, 1988). That is, the ideology of a powerful group infuses the ideas, language, practices and structures that comprise a discourse in ways that seem natural and taken for granted, or that appear to preclude the possibility of any alternatives (Fairclough, 1992). However, hegemonic power is never complete as it is built on alliances and the generation of consent from subordinate groups (ibid.). There are always people who recognise the ideological dimensions of a discourse, who are able to conceive of alternatives, and who are prepared to pose a challenge. Conflict arises because people are not passive subjects of social laws but are active agents who construct their own understanding of the world within the context of existing discourses (Habermas, 1988). Although they draw on maxims, or guidelines, that are grounded in the prior experience of others (ibid.), they are also capable of creating new interpretations and options upon which to base their actions (ibid.).

The ongoing struggle to shape discourse means that a discourse is not a unified, coherent whole but contains a range of conflicting interpretations and ideologies of varying degrees of influence. Nursing, as a social construct, reflects an ongoing debate between competing interpretations within nursing, and between nursing

and other related discourses. It does not exist in isolation but interconnects with, and is shaped by, other discourses, for example, those of medicine, health, family, work, class and gender. This is a phenomenon known as *interdiscursivity* (Fairclough, 1992). Within the meta-discourse of nursing, various strands of discourse compete, presenting nursing as, for example, a vocation, a profession, or a craft. These strands interweave to produce a complex social construct that is constantly being renegotiated and recreated in the daily activities of nurses, and in their interactions with others involved in the nursing project. The dominance of any one strand of discourse is a reflection of the power balance between its supporters and opponents, and of the extent to which the former have achieved a hegemonic position.

In describing the concepts of discourse and power within the context of interpretivist thought, I have outlined the theoretical foundations of critical theory, one of a number of approaches to research within that tradition. This approach is concerned with questions of human agency and power, and the impact of structure as well as discourse on interpretations of 'reality'. Critical theorists begin from the position that knowledge and its possession are intimately entwined with issues of injustice and exploitation (Porter S., 1998; Kincheloe and McLaren, 2000). Discourse analysis enables critical theorists to uncover the power dynamics that infuse social phenomena. In so doing they challenge existing knowledge, that appears to be natural and commonsensical, and develop new understandings that challenge injustice and exploitation (Kincheloe and McLaren, 2000). Critical research:

names the world as part of a larger effort to evaluate it and make it better (ibid.: 290)

Within this tradition, researchers are never content with 'merely increasing knowledge' (Horkheimer, 1972). Instead they engage in work that explicitly aims to address a particular injustice, and to provide the first steps towards political action. This political dimension of critical theory places it in conflict with dominant research discourses that reflect a positivist concern with detachment and objectivity. I address this conflict later in this chapter as part of an exploration of the issues that arise from studying nursing from the 'inside'.

Thus far in this chapter I have outlined the theoretical and epistemological foundations upon which this thesis is constructed. In the following section I move from a concern with epistemology to a description of the analytical approach that has enabled me to uncover the ideas, structures and power relationships that shape nurses' orientation towards, and experiences of, leaving nursing.

### **THE RESEARCH APPROACH**

In this study I use a critical hermeneutical approach to discourse analysis in order to explore individual nurses' understandings and experiences of leaving, within the context of NHS nursing. Critical hermeneutics requires the researcher to move constantly back and forth between an analysis of individuals and their context, between the whole and its parts, between the abstract and the concrete (Kincheloe and McLaren, 2000). In telling the stories of individuals within their context, the researcher illuminates both. The discourses and structures that shape a person's understanding and experience become apparent, as do the power dynamics that infuse the relationship.

This form of analysis is based on the interpretation of texts; that is, any human representation whether written, spoken or visual (Fairclough, 1992). Most commonly textual analysis centres on written/printed texts and on transcripts of verbal interactions. However, photographs, paintings, buildings and many other visual representations are also used to convey meaning and can therefore be subject to analysis (Gee, 1999). In this study I use a combination of interview transcripts, field notes and published documents. The latter group of texts is dominated by written material, but I also include a small number of visual representations of nursing. I describe my choice of texts in greater detail later in this chapter.

Unlike other research approaches, critical hermeneutics does not demand the application of a particular method. Gee argues that research is not about following a set of rules, but it 'adopts and adapts specific tools of inquiry and strategies for implementing them' (Gee, 1999: 6). The use of multiple methods and materials is advocated by Lincoln and Guba (2000) as one means by which a researcher can produce a valid, i.e. a plausible, analysis. Kincheloe and McLaren also suggest that a researcher should use a range of analytical tools in order to 'grapple' with the texts and to tell their stories in context (2000: 286). In this thesis I draw on the work

of Fairclough (1992) who advocates a combination of linguistic textual analysis and Foucauldian, critical discourse analysis. The former shows how discourse is drawn upon by individuals to represent reality, to enact social relations and to establish identity (ibid.). The latter is concerned with the broader socio-historical context of a text's production and interpretation, and demonstrates how ideology and power shape a discourse (ibid.; Parker, 1994). Linguistic analysis serves to ground the critical analysis in concrete examples of individual practice (ibid.; Gee, 1999), while critical discourse analysis provides a context for the meanings conveyed by individuals (Fairclough, 1992).

Linguistic analysis involves an examination of the author's choice of words and phrases, of the grammatical construction and the overall organisation of the text. Questions asked of the text include: How does the choice of this word rather than an alternative one affect the meaning conveyed (Fairclough, 1992)? What does the choice of metaphor convey (ibid.; Riessman, 1993; Coffey and Atkinson, 1996)? What does the grammatical construction indicate about the author's modality, or position relative to the statements made (Fairclough, 1992), or about their motivation (Burke, 1969)? What does the use of an active or a passive voice indicate about their sense of power (Fairclough, 1992)? How does the author position herself relative to others (ibid.)?

Critical discourse analysis asks questions such as: Who produced the text, for whom, and why? (ibid.; Parker, 1994) Who benefits from the discourse presented, and who does not? (ibid.) What is the relationship between the author and reader? (Fairclough, 1992) What are the themes that appear within the text? (ibid.) Which other texts and discourses inform this text? (ibid.) What are the unspoken assumptions that give the text meaning? (Gumperz, 1982) What is absent from the text, and do the absences represent something that cannot be spoken, or something that is deemed too obvious to state? (ibid.) How is the text shaped by the structural or organisational context in which it was produced? (Fairclough, 1992)

In addition to these approaches to textual analysis I have drawn on the field of narrative analysis. Story telling is a common means by which people talk about important events and experiences and give them meaning (Coffey and Atkinson, 1996). Narrative analysis provides a means by which researchers can examine not only individuals and events but also the cultural norms that shape their stories



(ibid.). It also calls attention to the role of the reader in the co-construction and interpretation of stories (Riessman, 1993), a point that I return to later in this chapter. Narrative analysis draws on the tools of textual analysis described above, asking how culture 'speaks' through the story (ibid.) and how the narrator understands and presents herself and her experiences to her audience (ibid.). Narrative analysis also pays attention to the structure of stories (Labov and Waletzky, 1966), the genre within which they are told, and the ways in which they breach the accepted canon within that genre (Bruner, 1991). Together, these tools provide a means by which researchers can explore the meanings that the author intends to convey, the meanings that the audience attaches to the story, and the nature of the discourses that frame these meanings.

Having described the research approach that informs this study, and the epistemological and theoretical foundations upon which it rests, I now move on to address one of the key methodological issues that it raises. That is, the implications of studying a group of which one is a member.

### **RESEARCHING NURSING FROM THE INSIDE**

From the inception of this project, my position as a nurse studying nursing has been one of the key methodological issues that I have had to address. The issue of 'insider research' is one that has generated a large literature, crossing numerous disciplines and epistemological positions and playing a central role in the concept of validity.

In the early stages of this study my thoughts on this issue were structured by the binary conceptualisation of researchers as insiders/outsideers and the need to balance the advantages and disadvantages of being a nurse, and therefore an insider. However, later in the process, I encountered a literature that shifts attention away from simple binary categories towards a concern with the complexity and dynamism of the researcher's position relative to participants, and to the research itself. Re-reading my research diary and the transcripts of interviews through this lens I realised that much of what I had written reflected a concern with the complexities of my position, which did not fall simply into the binary categories of insider/outsideer. This literature helped me to understand more deeply my thoughts, actions and interactions throughout the study and their

influence on the analysis reflected in this thesis. The multiplicity of roles and assumptions brought to the study by the participants and myself also became clearer, as did the power balances that infused our interactions.

In this section I explore the literature pertaining to the issue of 'insider research' and its relationship to this particular study. This forms the touchstone for subsequent reflections on my position relative to participants, and the part that my personal perspective has played in shaping the study. These reflections are integrated into the various sections of the chapter, appearing in the context of the relevant stage of the research process.

### **Epistemological Perspectives on 'Insider Research'**

Although the approach that I have taken to this study is interpretivist, the continuing dominance of the positivist paradigm within nursing requires some consideration of these two conflicting perspectives on insider research. The positivist paradigm views research conducted by 'insiders' with suspicion. Since the aim of social research conducted within this paradigm is to determine the objective truth of a phenomenon, membership of the group that one is studying is seen as compromising the validity of the results. As an insider, a researcher's ability to function as the detached, unbiased observer is questioned. The influence of this perspective within nursing research can be seen in Polit and Hungler's argument that, as researchers, nurses should recognise their biases and attempt to set them aside (Polit and Hungler, 1993). This concern with achieving an unbiased and objective position is reflected in much of the nursing literature surrounding insider-outsider research (e.g. Pugh et al, 2000; Bonner and Tolhurst, 2002; Hewitt-Taylor, 2002).

The positivist concern with the researcher's objectivity contrasts with the interpretivist claim that the researcher is inevitably a part of the world she studies (Hammersley and Atkinson, 1983; Habermas, 1988; Riessman, 1993; Punch, 1994; Holloway and Wheeler, 1996; Fine et al, 2000; Lincoln and Guba, 2000). Arguing from this position, Gadamer claims that everything we encounter is experienced and interpreted through the lens of our particular socio-cultural position or 'horizon' (Gadamer, 1975). Understanding social phenomena is not dependent on

setting aside our personal horizon but on fusing it with the horizons of others (ibid.). The point is not to set aside all affiliations and prejudices but to identify them and their impact on the study (ibid.).

The identification of personal affiliations is of particular significance within the critical theory school of research. Since it is not possible to separate 'facts' from the world of values and ideology (Kincheloe and McLaren, 2000), a researcher can never be a neutral observer, and research cannot be detached from the socio-political context in which it is conducted. Therefore,

researchers enter into an investigation with their assumptions on the table, so no-one is confused regarding the epistemological and political baggage they bring with them to the research site. (Kincheloe and McLaren, 2000: 292)

This approach to research offered a framework that enabled me to identify and work with the ways in which my personal and political experiences, values and beliefs motivated and influenced this study. I return to the subject of my personal values and motivations and their relationship to this study later in this chapter.

Critical theorists' concern with issues of power is not restricted to observing and analysing power relationships between subjects in the field. Since researchers are not detached observers, but participants in the world they study, an awareness of the balance of power within the research relationship is an important consideration too. In this respect, critical theory research and feminist research have much in common (for example, see Roberts, 1981; Oakley, 1981). The work of Fanon and Freire is influential in both traditions, enabling researchers to conceptualise the power dynamics and ethical issues that arise when researching marginalised and oppressed groups. Fanon argues that groups that are colonised by more powerful cultures tend to internalise the values and attitudes of their oppressors, colluding in their own oppression (Fanon, 1967). Freire claims that this collusion occurs because, in learning the language of the dominant culture, people lose their own voice and history, becoming 'imprisoned in a culture of silence.' (Freire, 1980). The loss of their own voice means that such groups are no longer able to find alternative ways of framing the world and so may not recognise their oppression or may be unable to conceptualise any alternative reality (Freire, 1980). This theory of colonisation provides a useful approach to understanding nursing as an occupational group that is subordinated to a more powerful group (medicine), that

struggles to find its own voice and that, as with many subordinated groups, tends to turn its frustration in on itself in the form of horizontal violence, self-depreciation and self-abuse (Fanon, 1967; Freshwater, 2000; Hadikin and O'Driscoll, 2000).

The silencing of the voice of marginalised groups places them in a vulnerable position relative to the researcher who has the power to represent them to others. Fine et al (2000: 109) argue that for the researcher to hide behind 'a cloak of alleged neutrality', and to withhold all personal information, is an abuse of this power. Having exposed the vulnerability of participants, the researcher remains invulnerable, using the voice of authority to represent subjects who have no way of shaping the analysis (ibid.). Fine et al argue that during interactions with participants, and in writing the final analysis, researchers should acknowledge their own vulnerability, balancing self disclosure with self restraint in order to prevent participants' voices being overwhelmed (ibid.). The researcher's role is not to assume absolute authority in presenting an analysis of participants' accounts since to do so is to risk reinforcing the dominant representations of reality. Instead, Fine et al advocate 'politically engaged social science' in which the researcher's role is to 'choreograph' participants' narratives in ways that shift their voices from the margins to the centre of national debates (ibid.: 119).

In order to draw out and fairly represent the voice of marginalised groups, critical theorists argue that researchers must engage with the people studied and actively avoid becoming distanced (Kincheloe and McLaren, 2000). The level of engagement, and the political dimension of critical research create a particular need for the disclosure of pertinent personal details, and a reflexive engagement with the study on the part of the researcher.

### **Reflexivity in Interpretive Research**

Within the interpretivist paradigm, the validity of research rests on the researcher's ability to engage reflexively with the research process, i.e. on her ability to recognise, understand and communicate to the reader her relationship with those studied, and the role she plays in the research process. Reflexivity has been defined as:

An acknowledgement of the role and influence of the researcher on the research project. The role of the researcher is subject to the same

critical analysis and scrutiny as the research itself. (Liamputtong and Ezzy, 1999).

Allen adds to this the need for an awareness of the effect that the research has on the researcher (Allen, 2004). Coffey (1999) describes the experience of fieldwork as a 'personal journey', a phrase that is also used by Carolan who argues that a developing understanding of herself is integral to her understanding of those she studies (Carolan, 2003). This recognition of the impact of the research on the researcher resonates with Gadamer's claim that, since the researcher's horizon is fused with, rather than replaced by, that of the subject, the horizons of both parties are altered by the encounter (Gadamer, 1975).

The purpose of reflexivity is to enable the researcher to achieve a theoretical distance from that which she studies, and to recognise that there is a range of perspectives other than her own, reflecting various alternative positions, places and identities (Pellatt, 2003). In describing the process of analysis, Powell echoes Gee's metaphor of discourse as a dance: in seeking to understand discourse the researcher continually steps backwards and forwards, viewing the issues from both a personal and a theoretical perspective (Powell, 1999).

The task of engaging reflexively with the research process is a delicate one in which the researcher must navigate between a level of self disclosure that facilitates communication with participants, and enables the reader to judge the value of the study, and one which privileges the researcher's perspective over that of participants, silencing their voices (Fine et al, 2000) and leaving the researcher open to criticisms of 'navel gazing' or narcissism. During interviews or fieldwork, finding the balance is a matter of negotiation with different participants, and of ongoing critical reflection on the part of the researcher. In writing oneself into the final text the ideal balance depends, to some extent, upon the preferences of the reader. Positions regarding the acceptable degree of self disclosure vary from total rejection within the positivist paradigm, to the argument made by auto-ethnographers that researchers can make a valuable contribution by making their own personal experiences the object of analysis (e.g. Ellis and Bochner, 2002). The position of the reader in this respect is not arbitrary but reflects her own horizon and the research tradition in which she is grounded. For example, a reader rooted in feminist sociology is likely to accept a greater degree of self disclosure than a

nurse, since nursing is a discipline that is strongly influenced by the positivist paradigm.

In the following section I explore the binary concept of insider/outsider research, as I understood it at the beginning of this study. This allows me to explicate the issues faced by a nurse studying nursing, as I understood them at the outset of the study, and the ways in which I sought to address these issues. I follow this with a critique of the conceptualisation of a researcher as either an insider or an outsider before presenting the more complex idea of positionality, in which the relationship between researcher, participants and study is viewed as dynamic and negotiated rather than fixed and inevitable.

### **Binary Positions: The Researcher as Insider or Outsider**

My initial concerns regarding my position as a researcher were shaped by a focus on the categories of insider and outsider. I asked myself: what are the implications of studying nursing from the inside? The literature addressing this issue has its origins in anthropology, a discipline which traditionally privileges the etic perspective of the outsider who immerses herself in an 'alien' culture. The emic perspective of the person researching her own culture is viewed with suspicion on the grounds that the person is blinkered by her familiarity with that which she studies (McEvoy, 2001). According to this perspective, the familiar and everyday become invisible to the insider who takes these aspects of life for granted and so focuses more on the unusual and the spectacular (Bonner and Tolhurst, 2002). Outsiders are argued to be in a better position to study a culture since everything is unfamiliar and therefore open to scrutiny (ibid.) and because they are able to take an objective view of their subject (e.g. Pugh et al, 2000; Hewitt-Taylor, 2002).

However, this argument has been challenged by those who argue that there are advantages and disadvantages to both the etic and emic perspectives (Hammersley and Atkinson, 1995). Advocates of 'insider research' claim that studies can be designed in ways that address the problem of over-familiarity, enabling researchers to draw on the greater insights, knowledge and contacts available to the insider (e.g. Durand Thomas et al, 2000; Pugh et al, 2000). As an insider, a researcher starts with the advantage of understanding the rules and norms within her group, and is likely to share many of the same values and feelings. She has been socialised into

the shared meanings of the group, understands the dominant discourses and is aware of the challenges and conflicts surrounding them. A wealth of experience as a group member and a common language enable her to grasp her colleagues' meaning quickly and to reduce the time spent on clarification and explanation. Her experience and knowledge enable her to make connections or ask questions that may not occur to outsiders.

The argument for studying nursing from the inside has been made by Altschul in relation to the subject of nurses' commitment, a central theme in this thesis. Altschul argues that nurses' commitment to their work is a concept that researchers have struggled to understand precisely because they are outsiders.

They often comment on the commitment they have witnessed, but they cannot explain it nor share in it. (Altschul, 1978: 126)

This observation reflects what Vidich and Lyman describe as a 'fundamental problem' for researchers, i.e. 'How is it possible to understand the other when the other's values are not one's own?' (Vidich and Lyman, 2000: 41).

The difficulties that a researcher encounters in communicating with, and understanding, a person whose language and cultural symbols they do not share are the subject of a paper by Bourdieu (1999). He argues that when an interviewer and an interviewee share a common symbolic language their communication is facilitated (ibid.). The potential for the researcher to be viewed with suspicion as a person with authority, who does not understand and may be judgemental, is reduced (ibid.). Furthermore, as an insider, a researcher is able to ask challenging questions without damaging the trust between herself and the interviewee, thus avoiding a phenomenon that Bourdieu describes as 'symbolic violence' (ibid.).

From this perspective, my status as a nurse can be viewed as an advantage, facilitating communication with, and understanding of, the nurses and ex-nurses who participated in this study. However, from the beginning I was aware of the ways in which being part of the group that one is studying also creates its own problems. In their major research project on understanding 'social suffering' in contemporary France, the attempts by Bourdieu et al to minimise 'symbolic violence' failed in a number of interviews (Bourdieu et al, 1999). These had to be discarded from the analysis as they became conversations in which a common shared core of identity between researcher and interviewee was unspoken precisely

because it was shared (Bourdieu, 1999). In these instances, the researcher and interviewee shared the same symbolic language to such an extent that nothing could be said because everything was already shared and taken for granted. In Gadamer's phraseology, the two parties shared the same horizon.

The problem of shared horizons is one of a number of disadvantages of insider research identified in the literature. Other disadvantages identified include the potential for role confusion on the part of researcher and subject; the potential for the researcher to rely overly on participants with whom she feels comfortable; and a tendency to focus on the dramatic and unusual rather than the routine and taken for granted (Bonner and Tolhurst, 2002). A range of practical means by which these disadvantages can be overcome are offered. For example, Pugh et al (2000), Bonner and Tolhurst (2002) and Durand Thomas et al (2000) argue that a research team comprising a mixture of insiders and outsiders balances the strengths and weaknesses of each perspective. As a PhD student, working alone, this was not an option. Instead I incorporated into the research a range of methods that are argued to facilitate reflexivity, to challenge the researcher's assumptions and prejudices, and to open up new avenues of enquiry that are not immediately apparent to an insider.

To some extent the problems posed by my status as an insider were reduced by my early experiences as a nurse that placed me in a position that Sennett would describe as 'alienation' (Sennett, 1998). In a study of working relationships within a bakery, Sennett describes how one of his key informants was a man whose experiences had prevented him from being fully socialised into the group within which he worked. He could, to some extent, step away from the group and view their interactions critically (Sennett, 1998). In the early months of my nurse training in the military I went through a period of bullying that led me to question the norms and expectations of the occupation into which I was being socialised. Although I went on to graduate as a nurse, my socialisation was tempered by the continuation of the critical perspective that I developed in those early months. As a result I occupy a space on the boundaries of nursing as both an insider and an outsider.

Despite this initial advantage, which contributed to my questioning of the conventional wisdom regarding nursing shortages, I also needed to find ways that



enabled me to gain greater distance from the study, to see nursing from new and unfamiliar angles, and to separate my own thoughts and feelings from those of the nurses I was studying. I began by making the deliberate choice of a non-nurse as a second supervisor so that she would challenge my assumptions, identify areas that I had overlooked, and provide alternative perspectives and avenues to pursue (Pugh et al, 2000). I also discussed my work with non-nursing friends and family who challenged my assumptions, made me think more deeply about my analysis, and enabled me to connect my own work and experiences to other fields.

During the interviews, my prior training in counselling was helpful in that it taught me to recognise and analyse my personal responses to participants. This self awareness and ongoing reflection in the interviews allowed me a greater control over my personal responses and provided me with a source of deeper reflection after the interview.

Throughout the study I also maintained a research diary in which I recorded my thoughts and feelings about the research process, the decisions I made and the reasoning behind them, my thoughts and responses to books and papers I read, and to the people I interviewed and spoke with (Hewitt-Taylor, 2002). This proved to be an invaluable means of stepping away from my work and reflecting on it.

Although my diary was an extremely useful tool, I was still writing from the basis of my own perspective. Although I tried to look at my thoughts from a variety of angles I was still working from within my own world as a nurse. I therefore decided to see what would happen if I was interviewed by a non-nurse using my own topic guide. My husband, who has considerable experience in research interviews, offered to help me with this exercise when I had completed around half of the interviews. I taped and transcribed this interview and used it to compare my own responses to those of the participants that I interviewed myself. The transcript was used purely as a means of reflecting on my own responses and was not analysed with the other transcripts.

Recognising the issues surrounding being an insider or an outsider provided a valuable starting point for reflection and enabled me to disentangle myself from other nurses and to see where some of my own responses and beliefs come from. However, on re-reading earlier drafts of the thesis, it became clear that these concepts are not sufficient to explain the complexity of my interactions with

participants and with the analysis, or the impact that conducting this research had on my own personal horizon.

### *Critiquing the Binary View of a Researcher's Position*

The categories of insider and outsider have been criticised on the grounds that they assume the existence of an objective reality as the reference point against which the researcher's position is judged (Allen, 2004). As such they sit uneasily within an interpretivist approach to research. The inadequate conceptualisation of these terms in many papers is also problematic. Some authors use the term 'insider' to refer to their status as a nurse (Allen, 2004), while others link it more specifically to their employment in the organisation studied (e.g. Pugh et al, 2000; Hewitt-Taylor, 2002). The question of what the researcher is in or outside of is frequently left unanswered, and the possibility that a person may be both an insider and an outsider is left unexplored. For example, Tolhurst makes reference to her dual position as an insider and outsider in a study of the practice of nephrology nurses (Bonner and Tolhurst, 2002). However, she dismisses this as irrelevant to the paper which is concerned with the binary positions of insider and outsider. The reader is given no further clue as to the sources of her dual status and a potentially interesting and useful avenue of enquiry is set aside in favour of a table of the advantages and disadvantages of being an outsider.

Further problems arise when simple binary categories are attached to lists of associated advantages and disadvantages (e.g. Bonner and Tolhurst, 2002). This perspective carries the potential for reflexivity to be replaced with a 'recipe book' approach in which researchers identify themselves as insiders or outsiders with little apparent reflection on the meaning or implications of these terms. Reflexivity is replaced by a list of the measures taken to counter the disadvantages cited in textbooks and journal articles.

The binary categorisation of insider/outsider can also be criticised for tending to privilege the interpretation of the researcher, ignoring the perspective of participants. For example, Pugh et al (2000) describe themselves as insiders or outsiders on the basis of whether or not they are employed in the hospital studied, with no reference to how their colleagues under observation perceive them. As a fellow employee, Pugh is assumed to be seen as a friendly face, and the possibility

that some colleagues could view her as a 'collaborator' or an informant for management is not considered. This unquestioning acceptance of 'common-sense' assumptions about insider/outsider status is criticised by Allen who argues that greater attention needs to be paid to the ways in which the relationship between researcher and subjects is accomplished in the field (Allen, 2004).

The emphasis on binary categories is also problematic in that the categories are often treated as static and simple with more or less fixed attributes, discouraging any reflection on the complex nature of, and changes in, the researcher's position. The implications of this variability are illustrated by Savage, who describes an experience in which the time that had elapsed since she had last practised as a nurse limited her ability to engage in participant observation in a hospital setting (Savage, 2000).

The issues raised above indicate that a more complex view of the position of the researcher relative to her study and participants is needed. In the following section I move away from a concern with the fixed positions of insider versus outsider to the concept of positionality that incorporates a consideration of the complexity of the positions of both researcher and subject relative to each other, and the fluctuations and contradictions in these positions.

## **Positionality: Negotiated Positions in Research**

An alternative perspective on the researcher's status is provided by the concept of positionality which centres on the idea that the relationship between the researcher and researched is a complex and dynamic process rather than a matter of fixed, binary roles (Mullings 1999). Researcher and participant each draw on a different set of personal roles and attributes, stereotypes and assumptions in presenting and positioning themselves relative to each other. Each combination produces a different dynamic, and positions change throughout the course of an interview.<sup>13</sup> In an exploration of her position as a midwife researching birth experiences in Britain and Pakistan, Chesney recognises the influence of multiple roles on her relationship

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<sup>13</sup> The concept of positionality and the importance of self-presentation draw on the symbolic interactionist approach to understanding the concept of self. The work of Goffman (1990) is particularly important in this respect. For a more detailed exploration of the concept of identity and self-presentation see chapter five.

with participants. She argues that in interviews she is not simply a researcher, she is also a midwife, a white, English woman and a mother, and that all of these roles contribute to her position relative to the women interviewed (Chesney, 2000). Although she can choose to stress some roles over others, she cannot completely control either her own presentation or the way in which the women perceive her.

Although I attempted to focus on my role as researcher during interviews, most participants either knew or guessed that I was a nurse, and several explicitly checked this. My identity as a nurse also infused the interactions in many ways including in the style of communication I adopted, as I describe later in this chapter.

My identity as mother was also an ever-present influence, explicitly when speaking to participants about their experiences of combining nursing and parenthood, but also in less obvious ways. For example, my motherhood, as well as various other aspects of my personality and life, was apparent in the pictures on my walls and desk. I was able to gain similar glimpses into the more personal lives of participants when interviews were conducted in their offices. In each interview the participants and I interacted not as mono-dimensional characters but as whole people presenting a variety of different aspects of ourselves in response to our perceptions of each other.

Mullings argues that, throughout the research process, a researcher is faced with the ongoing challenge of finding positional spaces that foster trust and co-operation with participants, and with those who have the authority to grant or deny access to them (Mullings, 1999). A researcher can never be located simply on one side or the other of the insider/outsider boundary but may present herself as being so in order to gain access to information (*ibid.*). The advantages and disadvantages of each position depend on the situation, and on the person with whom the researcher is interacting. Positional spaces fluctuate constantly and, although a researcher can influence them to some extent in the way she presents herself, some attributes such as race and gender are immutable. Furthermore, the way in which the participant perceives the researcher can never be entirely predicted, controlled or understood (*ibid.*). Each pairing of researcher and researched produces a different dynamic and evokes different meanings, reflecting the cultural norms and stereotypes evoked. For example, an interview with a senior manager involves a different power dynamic to one with a junior employee; an interview between a female

researcher and female participant will involve different assumptions and interactions than that of a female researcher and male participant (Herod, 1993).

The complexity of positioning oneself is also apparent in Allen's account of her experiences of participant observation in an English hospital (Allen, 2004). She identified herself as a nurse and as such was treated as an insider to the extent that the nurses she observed did not feel the need to explain their jargon (*ibid.*). However, much of the paper concerns her attempts to overcome the obstacles posed by being perceived as an outsider by those in authority, and by the staff on the wards being studied. The language she used, the clothes she wore and the physical spaces she occupied all contributed to the way in which she positioned herself in ways that encouraged trust and openness among both management and staff (*ibid.*). The task of finding these positional spaces was made more complex for both Mullings and Allen in that they had to gain the trust and respect of both workers and management; both researchers encountered suspicion that they were spies for management. The fragile and changing nature of positionality is illustrated particularly clearly by Mullings who lost the trust of workers in one company when they observed a manager whisking a questionnaire out of her hands, claiming that she wanted to check that it had been completed fully (Mullings, 1999).

In contrast with the simple categorisation of myself as a nurse, and therefore an insider, the concept of positionality facilitates a more complex conceptualisation of my position within this study. As a nurse I do share, to some extent, a common culture with participants, which has the potential for easing communication and fostering trust. However, neither the participants nor I are just nurses, and nursing is not an homogenous entity. Within this framework exists the possibility of presenting myself, and of being perceived, as both an insider and an outsider. For example, interviewing staff nurses, charge nurses and nurse managers involves subtly different power dynamics. I share a degree of common experience with staff nurses that is not present with charge nurses or managers. At the beginning of the study I shared many staff nurses' suspicion of and frustration with management, and so it was necessary to recognise and reflect on this prejudice in order to find a position from which I could hear managers' accounts sympathetically. This is one of the areas in which my personal horizons have changed most radically.

Conducting these interviews challenged my prejudices and enabled me to see past the manager to the person behind the role, caught between the roles of nurse and manager, sharing other nurses' struggle to 'do the job' in difficult circumstances, compounded by criticism and judgement from both nursing and managerial colleagues.

Although I am a nurse, many of the participants work in specialities with which I am not familiar. This enabled me to emphasise my 'outsider' status and to draw out more detailed accounts of their experiences and thoughts. I was also able to draw on my history of working within the same city, and in some cases the same Trusts, to present myself as an insider who 'knew the score' and could be trusted. However, choosing to emphasise this aspect of myself, and identifying my funders as the Scottish Executive rather than an NHS Trust, was an important part of settling some participants' fears that I might be reporting back to their managers or employers.

Balancing my positions as insider and outsider was a particularly difficult task while interviewing a nurse who had been a colleague on the same ward some years previously. In this interview I had to find ways to establish distance and encourage her to vocalise her thoughts in situations where our shared experiences would normally have obviated the need for explicit detail. As McEvoy (2001) notes, this is a delicate task carrying the potential for damaging an interaction if it is handled badly. I chose to explain my need to ask for such detail before the interview began, a strategy which proved to be successful. Had I not identified this as a potential issue prior to the interview I could have shared McEvoy's experience of failure in trying to use more subtle ways of drawing this participant out (*ibid.*).

With other participants my position was complicated by the fact that we have links to the same University Department. With one, the relationship that we had already established as fellow students seemed to overcome any concerns that she might have had about my trustworthiness. However, the power dynamic with another participant, who is a lecturer in my department, was very different. Our interaction was constrained by my inability to let go of my role as student, and his apparent concern, as a lecturer, to maintain his status and keep confidentiality within the department. As a result our interaction was stilted and awkward, punctuated by

long pauses in which I struggled to find ways in which to ease our communication and in which he seemed to be choosing every word with care.

Another significant factor in finding positional spaces was my identity as a mother. With some participants who are also parents this offered the potential for closer interaction, since we shared the experience of juggling career and family. However, with others, presenting myself as an 'insider' in this respect carried particular dangers. The fact that we lived in the same village, and our children attended the same playgroup, created a situation in which I had to work particularly hard to present myself as a sympathetic and non-judgemental listener who would not disclose sensitive information to their neighbours. However, with another participant who is young and single, and who suspects that some nurses use their children as an excuse to 'get the best shifts', my identity as a mother was less conducive to communication on this sensitive subject. The challenge in this interaction was to overcome the barriers to communication that my status as mother and nurse could have posed. I consciously tried to position myself as interested and non-judgemental researcher, setting aside my personal annoyance at her attitude, and trying to remember how I had felt about shift allocations as a young, single staff nurse, struggling to maintain some degree of social life.

The concepts of positionality and reflexivity bring a new dimension to a consideration of the researcher's status as insider or outsider, raising the question of what she is an insider or outsider to, and how this position changes throughout the research process. Interactions within the research setting are revealed as complex and dynamic, reflecting the ways in which those involved perceive, present and position themselves relative to each other. In the following pages I present the process by which this thesis was developed, including at each stage reflections on the relationship between myself and participants in the study, the research process and the final analysis and presentation.

## **THE RESEARCH PROCESS**

### **BEGINNING THE STUDY: UNPACKING MY INFLUENCE ON THE INCEPTION AND DEVELOPMENT OF THIS STUDY.**

From the earliest stages of a project, the researcher's particular lens on the world, her experiences, beliefs and values, shape what she identifies as a potentially interesting topic for investigation (Punch, 1994). They also influence whether or not she views the subject as worth investing in. Had I not been a nurse I might not have recognised the dissonance between official accounts of nurses leaving, and nurses' own experiences and understanding of the issue. My personal values and perspective on nursing led me to believe that this dissonance merited investigation. My belief that there is a need for a greater contribution from nurses in this arena, combined with my personal circumstances, gave me sufficient motivation to leave clinical nursing and apply for a PhD Studentship. In this section I offer the reader some insights into relevant aspects of my history as a nurse, and into the beliefs and values that motivated my decision to leave nursing and that have shaped this study throughout.

### **A Personal Lens on Nursing: Experience**

Earlier in this chapter I described my early experiences as a student that led me to view nursing from the position of an 'alienated insider'. My experience as a nurse was characterised by a tension between my passion for nursing and a deep frustration with circumstances that often prevented me from 'doing the job well'. From my earliest days as a student I developed a strong attachment to nursing and found it difficult to imagine being anything other than a nurse. Nursing transformed me from a shy schoolgirl into a confident adult with a sense of purpose and direction. I found powerful rewards in the connections I made with patients and their families, and in seeing the impact of our work on their lives. However, although I love nursing, many of my most positive experiences took place within a very negative environment. Organisational obstacles, a lack of resources and staff, and the attitudes of a few of my colleagues made it almost impossible at times to maintain patients' safety, let alone their dignity as human beings. The stress of trying to achieve what I regarded as an acceptable standard of care in such circumstances was compounded by a working culture in which support was often lacking. To ask for help was to admit weakness. Increasingly I found myself



asking, 'Who cares for the carers?' in relation to informal carers in the home, to my fellow nurses and to myself. My belief, that it is necessary to care for oneself in order to be fit to care for others, was at odds with my experience of the culture in which I worked. Despite the difficulties I encountered, I was motivated to persevere by the enormous rewards of the job and the hope that I could make it work, if only I tried hard enough and could find the right speciality/ward/team to work in. I continued nursing for ten years during which time my passion for the work convinced me to stay, despite mounting levels of frustration and fear. However, with the birth of my son I was forced to rethink my priorities. Embarking on this study gave me the opportunity to maintain my links to nursing and to continue making a contribution, albeit in a different sphere.

### **A Personal Lens on Nursing: Values**

Perhaps the most influential belief I hold in relation to this study is summarised by Tschudin:

That people matter is the basis of all ethical behaviour. Because caring for people is the *raison d'être* of nurses and nursing, the basic belief of nurses and nursing is that people matter. (Tschudin, 1999: 18)

As with many nurses, my belief in the principle that people matter is rooted in my upbringing, and has been honed by my occupational socialisation and experiences as a nurse. I believe that to treat anyone as less than an individual and vulnerable human being is to create an injustice. Furthermore, I support Tschudin's argument that it is not possible to qualify the principle that 'people matter' without creating a further injustice (ibid.). On these grounds, one cannot argue that patients should be treated with respect as vulnerable human beings whilst denying oneself or other nurses the same consideration. People matter. Nurses are people. Therefore, nurses matter too.

This ethic of care that underpins nursing has been criticised on the grounds that it is idealistic. For example, Dingwall and Allen argue that, in order to address the widespread dissatisfaction within their profession, nurses need to let go of their idealism and work within the realities of the system as it stands (Dingwall and Allen, 2001). Such a course of action is presented as the rational thing to do. Nurses' dissatisfaction with the dehumanising tendencies of the NHS is presented

as pathological and the possibility that the system itself may be flawed is overlooked. Such an argument compounds nurses' experience of voicelessness, and adds to the myth that the structure and organisation of healthcare are the inevitable result of the laws of economics and rationality. Such a position labels any opposition to the status quo as irrational, idealistic, and politically motivated, masking the political dimension of choices made by policy makers and managers that stress economic efficiency over the ethic of care (e.g., Stiglitz, 2003).

In accordance with the principles of critical theory described above, I acknowledge that my agenda is explicitly political. I believe that there is a need for nurses to make their voices heard in order to balance the argument for organisational efficiency with a consideration for the humanity of all those who are cared for, or work within, the NHS. Until this balance is achieved the injustice of the dehumanisation of both staff and patients seems set to continue.

### **A Personal Lens on Nursing: Aims**

My aims in conducting this research can be divided into two categories, the personal and the political. On the personal level I began with a desire to contextualise my own experiences. I wanted to determine whether the dissonance between my experiences and the existing analyses of the exodus from nursing simply reflected my own idiosyncrasies, or whether nurses who choose to leave are more generally misrepresented.

On the political level, I aim to provide a means by which nurses' voices can be heard in the debates surrounding the 'nursing exodus'. The marginalisation of nurses' voices is a well recognised phenomenon (e.g. Wicks, 1998; Tschudin, 1999; Davies, 1995). Attridge and Callahan (1989) argue that nursing is poorly understood and lowly valued by outsiders and that this situation is unlikely to change until nurses 'come to value what they believe and do' (ibid.: 62) and to describe it to others.

As the study progressed, I found that these claims were supported by a strong and widely shared sense of frustration among participants at their feelings of being invisible, ignored and voiceless. The response that I received from participants suggests that they too saw this study as an opportunity to make their voices heard. Bourdieu argues that:

Certain respondents, especially the most disadvantaged, seem to grasp this situation as an exceptional opportunity offered to them to testify, to make themselves heard, to carry their experience over from the private to the public sphere ... It even happens that, far from being simple instruments in the hands of the investigator, the respondents take over the interview themselves. The density and intensity of their speech, and the impression they often give of finding a sort of relief, even accomplishment, convey along with everything else about them, a joy in expression. (Bourdieu, 1999: 615)

Bourdieu's description perfectly describes the response of many participants in this study. Several were so keen to talk that they launched into their accounts before I had a chance to ask the first question or even switch on the tape recorder. These people were extremely focused, and rarely moved away from the subject of the interview, despite an almost complete lack of interventions on my part. Their passion for, and deep frustration with, nursing were clear in the richness of their accounts, in their body language and tone of voice. Even the transcripts of these interviews look different, with very little paper visible between the dense mass of words. At times I felt that in asking them to talk I had broken through a dam and I struggled to maintain my footing in the torrent of words. These nurses had clearly reflected deeply on their occupation in private, and were intelligent, articulate and well informed people. After the interviews, several of them commented on the lack of opportunities to express themselves in this way and thanked me for listening.

Although the attitudes, beliefs and behaviour of individual nurses are central in shaping the form and development of nursing, the perspectives of individuals tend to be lost in the search for abstract, generalisable 'truths' (Kincheloe and McLaren, 2000). Cavanagh comments on the frequency with which nurses responding to questionnaires use the margins to qualify, or add depth to their answers (Cavanagh, 1989). Critical discourse analysis allows me to bring the voices of individual nurses to the fore instead of viewing them as an interesting but inconvenient aside. Contradiction and complexity in nurses' accounts becomes a reflection of the messy and contested nature of nursing as a social construct, rather than a methodological problem. A critical discourse analysis of such accounts opens the possibility of exploring the power dynamics that underpin these conflicting interpretations, uncovering the multiplicity of influences on nurses' understanding and experience of their work, and hence on their orientation towards leaving nursing. This is a particularly important consideration in this

thesis since issues of power and conflict lie at the heart of participants' experiences of nursing. As I demonstrate in subsequent chapters, to be a nurse is to live and work in a world of conflicting ideals and power imbalances, of high expectations and impossible choices.

In the context of the problems faced, or posed, by the nursing workforce, the absence of strong nursing voices in the public arena would seem to be a serious barrier to developing a meaningful understanding of the issues. In this study I aim to contribute to a deepening of our current understanding of nursing workforce issues, with an analysis that is grounded in nurses' own understanding of nursing and its problems.

While policy makers may be able to address some of the issues raised within this study, there will inevitably be some areas that can only be addressed by nurses themselves. Therefore, my second political aim is, in the critical theory tradition, to 'name the world' of nursing (Kincheloe and McLaren, 2000: 290), making explicit the assumptions, values and power dynamics that dominate nursing culture. In so doing I aim to make the implicit and taken for granted explicit and open to challenge. I aim to stimulate open debate and to encourage nurses to participate actively in shaping the future of their chosen profession.

This dual aim means that the thesis is written with two different audiences in mind, and is not simply a text written by a nurse for nurses. In order to make nursing more intelligible to 'outsiders', I have paid particular attention to the jargon and short hand that nurses take for granted. I offer translations and explanations in the form of footnotes, and ask for patience from nursing readers to whom these may seem unnecessary.

### **SELECTING / CREATING TEXTS FOR ANALYSIS**

In this section I describe the process by which I generated, or selected the texts upon which this analysis is based. To produce a plausible account of the phenomenon of leaving nursing I have analysed a range of texts that convey individual nurses' thoughts and experiences, or that enable me to place these within the broader context of NHS nursing. The texts comprise a series of transcribed interviews with practising and ex-nurses, and a large number of published texts including extracts from nursing textbooks, research papers, journal articles, letters

and books written by nurses, codes and guidelines produced by professional nursing bodies, policy documents, journal and newspaper articles and research papers relating to the provision of healthcare.

I begin by describing the process by which I generated the texts that reflect the thoughts and experiences of individual nurses. I describe the choices I made regarding the selection of particular groups of nurses for inclusion in the study and the recruitment of participants. I introduce each participant, briefly, before describing the interview process. Since the process of transcription is an integral part of analysis, this aspect of these texts' creation is included under the latter heading. Finally, I turn to the selection of published texts that enable me to locate the interview transcripts within the context of NHS nursing and the political economy of healthcare in Britain.

### **Creating Transcripts of Individual Nurses' Reflections on Leaving Nursing**

This study is centred on a series of in-depth interviews with 28 nurses and ex-nurses that were conducted between May 2001 and February 2002. The majority, but not all, of the participants were drawn from Trusts within the city of Edinburgh. In deciding which people to interview I used a theoretical approach to sampling that allowed me to be flexible in my decisions and to follow through on new ideas. In this I was influenced by the ideas of Glaser and Strauss (1967). Theoretical sampling differs from other approaches used within positivist research in that the validity of the study is judged according to the researcher's rigour in seeking both convergence of opinion and contradiction (Lincoln and Guba, 2000; Riessman, 1993; Glaser and Strauss, 1967), rather than on the representativeness of the sample. My intention was, therefore, to find as many different perspectives on nursing as possible in order to see the extent to which the dominant discourse shapes nurses' perspectives, and to identify instances of conflict and challenge.

## **Selecting Participants**

### *The Decision to Include Practising as Well as Ex-nurses*

I began with the decision to interview practising nurses as well as those who have left. This allowed me to explore the full range of experiences and perspectives from happy, satisfied nurses, through those who were dissatisfied in their work, to those who had actually left. I needed to do this in order to understand the differences between the three groups. Interviewing nurses who were happy in their role was also important to provide a counterbalance to my own negative experiences. Furthermore, I did not want to limit my analysis to a group of unhappy nurses and omit the positive and very rewarding aspects of being a nurse.

My first interviews were conducted with practising nurses so that I could establish a basic understanding of what it means to be a nurse before focusing on the issues of dissatisfaction and leaving. However, nursing is a broad church, encompassing an enormous range of specialities, and in order to keep the numbers of interviews to a manageable size I had to decide which groups of nurses to include in the study and which to exclude. I began with the decision to focus on qualified nurses on the grounds that they have passed through the initial student phase of wondering whether nursing is the right choice for them, and have demonstrated a commitment to nursing by registering at the end of their training. This is particularly important given the trend, identified in chapter one, in which large numbers of students do not complete their training or choose not to register after they qualify. Furthermore, students have yet to complete their initial period of socialisation and therefore the issues surrounding their decisions to leave are likely to be different from those of qualified nurses.

### *The Decision to Limit the Study to General Nursing*

I then decided to limit my study to nurses working with the physically rather than the mentally ill. Psychiatric nursing stands out from other specialities in several key ways that point to a very different culture and discourse of nursing. Psychiatric nursing has a different history (e.g. see Dingwall et al, 1988), and contains a far greater percentage of male nurses than general nursing. These differences manifest in the different attitudes towards political activity, with psychiatric nurses being

more willing than those in other fields to engage in industrial action (Salvage, 1985). A study of the differences between psychiatric and general nursing discourses would have been interesting but was not feasible with the limited time and resources available.

### *The Decision to Include Community Nurses*

I decided to include community nurses in the study on the grounds of anecdotal reports from nursing colleagues that dissatisfied hospital nurses tend to move to community nursing in the expectation that the pace of work will be less frenetic. This observation was also voiced by Heather<sup>14</sup>, a community nurse manager who assisted in the planning of this study as well as contributing an interview (personal communication, 2001). A study conducted in 1977 claimed that graduate nurses were more likely to gravitate towards community nursing, a trend that may have reflected a desire for greater autonomy (Scott Wright et al, 1977). Since this was also the path that I had taken, I wanted to see whether this study still has relevance today, why other community nurses choose this particular speciality and whether their expectations have been met.

The practising community nurses in this study all work within the same area of the city, which was selected in collaboration with their Trust managers on the basis that there were fewer research projects being conducted with these nurses than with those in other areas of the city.

### *Selecting Hospital Nurses*

The choice of nurses from within hospital-based specialities was less straightforward given the enormous number of specialities that I could have recruited participants from. Instead of dividing nurses in this conventional way I decided to view nursing specialities as reflecting two main orientations towards patient care. I looked for two specialities in which the emphasis is on communication and the development of long-term relationships with patients, and two in which there is a high turnover of patients and an emphasis on technical

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<sup>14</sup> Heather is a pseudonym. The issue of confidentiality and protecting participants' identity is addressed later in this chapter.

nursing. These categories reflect the assumption that I refer to in chapter one that nurses can be divided into 'vocationalizers' and 'professionalizers'. I expected nurses in these two groups to be attracted to specialities that fitted their perspective on nursing.

*Category One* comprises those nursing specialities that emphasise communication and relationship building. This category created difficulties from the start. In previous years I might have recruited from some of the long term care of the elderly wards but these have now been closed and their occupants transferred to nursing homes. The research co-ordinator from the participating acute Trust commented that the ever shortening period of patients' hospitalisation is a frequent source of complaints among nurses who do not have opportunity to get to know their patients. This is the case even in specialities where patients previously spent long periods of time receiving treatments. This led to my choice of the first department<sup>15</sup> in which patients were admitted for short periods on a regular basis to receive treatments that lasted for many months. This enabled the nursing staff to develop a relationship with them over the course of a number of hospital admissions. Although the treatments were often highly complex, there was a strong emphasis in this department on the need for strong nurse/patient relationships in order to support patients through their illnesses. The second department in this category specialised in rehabilitation and conformed more closely to my original criteria.

*Category Two* comprised those nursing specialities that emphasised technical interventions, knowledge and skill and participants in this category were drawn from two departments. The first specialised in extremely complex treatments and included a High Dependency Unit (HDU). However, patients in this department were not usually treated over long periods and many were too ill to develop a relationship with their nurses at first. The second department in this category specialised in treating acutely ill patients who required surgery for their condition. Again, inpatient stays were short and technical treatments and monitoring formed a large part of the nurses' work.

As the interviewing progressed it quickly became clear that the distinctions that are made between vocationalizers and professionalizers are spurious. As I show in

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<sup>15</sup> Each department comprises a number of wards providing different aspects of care for patients with related conditions.



chapter three, the participants all share a strong belief in communication and relationships as the basis of all nursing. Although ideas of the good nurse as having an innate ability to communicate appear, the consensus across the groups is that communication is a skill that must be learned and developed throughout a nurse's career. Nurses in both categories speak of the importance of good basic care grounded in an understanding of patients as whole people.

### *The Decision to Include Health Visitors and Managers*

In addition to recruiting hospital based general nurses I also wanted to include people who would help me to understand the boundaries of nursing. I needed to know what is and is not seen as leaving nursing. I therefore included four managers and two health visitors in the study. The question of whether people employed in these areas are still nurses is contested. The hostility that many nurses feel towards managers, and particularly those with a nursing background, is well documented (e.g. Salvage, 1985; Davies, 1995; Cole, 2001) and Snell cites the case of a manager who left the NHS because she found that she could no longer 'wear two hats' as a nurse and manager (Snell, 2001: 26-27). McIntosh and Dingwall describe health visitors as being pulled in two directions as people who are nurses but better than nurses (1978: 129). Many see themselves as nurses who have moved on to a 'more sophisticated and progressive' practice (ibid.: 129). The recent replacement of the UKCC with the NMC created controversy over the way in which health visiting was subsumed under the banner of nursing (e.g. Houston, 2002) and therefore the question of the boundaries between nursing and health visiting was a topical one at the time of these interviews.

### ***Recruiting Participants***

#### *Recruiting Practising Nurses*

Having identified the hospital departments and community locality from which I would recruit participants, I arranged to meet the hospital staff on the wards concerned and I spoke to the community nurses during one of their regular locality meetings. In these meetings I explained the purpose and nature of the study and

asked for volunteers. The pressure of work in some departments was such that I was not able to do this and so I had to rely on the distribution of letters among the staff. The response of nurses in these meetings was sometimes intense and on several occasions I found myself in the middle of heated discussions about the state of nursing and the reasons why nurses leave. On one such occasion I struggled to end the meeting as I had only been given ten minutes and the debate looked as if it might continue all afternoon. Although these meetings were arranged for the purpose of recruitment I took notes of the discussions, which provided extremely valuable material for analysis.

In recruiting practising nurses I was conscious that some might not want their colleagues and employers to know that they had participated. To protect their anonymity I handed out a form asking for basic biographical details of volunteers and a contact number or address. These forms also allowed me to select participants according to their biographical details as well as their speciality. I tried to choose people with a spread of ages, grades and working experiences, and with differing family backgrounds. I included nurses working both full and part time. Towards the end of the interviews I had the opportunity to include an ex-nurse who had trained and worked as a nurse in North America before moving to Britain and working as a hospital manager. Initially I wondered whether to include her since she came from another nursing culture, but I decided that she would provide a valuable contribution from a person who could take alternative perspectives on NHS nursing. Her description of the differences between nursing in her own country and in Scotland did indeed prove to be very helpful.

### *Recruiting Ex-nurses*

The image of a mass exodus from nursing suggests that there are many ex-nurses whom I could have interviewed. However, recruiting ex-nurses proved to be rather more difficult than I had expected. My 'leavers' were people who had made a conscious decision to leave nursing as the result of dissatisfaction rather than because they were forced by circumstances or preferred to look after their children full time. I began by distributing letters to the managers of departments involved in this study and to the nursing staff, and asking them to pass them on to anyone

they knew who had left nursing. The managers looked through their records but were unable to identify more than a handful of nurses who had left nursing altogether. Of these, none responded to my letter.

By the end of the study I had interviewed six people who fulfilled my criteria for 'leavers' although I omitted one account from the analysis for reasons I explain later in this chapter. Practising nurses involved in the study identified three of these; one was a neighbour of mine; one I found by following up an article in a nursing journal; and one was an acquaintance of a colleague. However, my accounts of leaving nursing are not restricted to this group of 'leavers'. Once again, attempts to categorise nurses in simple ways disintegrated as I found that two of my practising nurses had active plans to leave, two had left and then returned, and two had come extremely close to leaving before deciding to persevere.

### ***The Participants***

<b>Table Three : Overview of Participants</b>					
<b>Pseudonym</b>	<b>Age group</b>	<b>Speciality and grade</b>	<b>Dependants</b>	<b>Practice and breaks</b>	<b>Biographical notes</b>
Anne	50-60	G Grade district nurse.	Mother of two adult daughters.  Has one grandson	Practising F/T <sup>16</sup> .  Took breaks when children were born. (There was no maternity leave at that time.)  Planning to retire in the next few years.	Trained as a nurse on leaving school <sup>17</sup> . Has worked in several areas including orthopaedics and theatre. Worked nights while children were small.  Trained as a district nurse and has worked in the community for many years.

<sup>16</sup> F/T – full time, P/T – part time

<sup>17</sup> Unless I specify otherwise, training refers to a college-based training leading to qualification as a Registered General Nurse (RGN). Where a participant trained as a State Enrolled Nurse (SEN) or completed a Project 2000 diploma or nursing degree I note this.

Table Three : Overview of Participants					
Pseudonym	Age group	Speciality and grade	Dependants	Practice and breaks	Biographical notes
Barbara	40-50	G grade district nurse.	No dependants	<p>Practising F/T</p> <p>Took 11 months out to care for her father when he was ill.</p> <p>Later left nursing to travel after a difficult period but returned to district nursing.</p>	Trained as a nurse (SEN) <sup>18</sup> on leaving school. Later converted to RGN. Began midwifery training but didn't enjoy it. Worked in paediatrics before moving into community nursing.
Christine	30-40	Category 1 hospital nurse. G Grade specialist	Mother of a small child	<p>Practising F/T</p> <p>No breaks in practice except for maternity leave.</p>	<p>Trained as a nurse after a brief period working abroad as a nanny. Has 'worked her way up through the ranks', only taking time out for maternity leave.</p> <p>Considered leaving nursing at one point but no longer feels this way.</p>
Claire	30-40	G Grade health visitor	<p>Mother of teenage twins.</p> <p>A lone parent for many years before marrying approximately five years ago.</p>	<p>Practising F/T</p> <p>No breaks except the minimum time for maternity leave.</p>	Trained as a nurse on leaving school. Became pregnant during final year of training. Worked night shifts in order to combine commitments. Became senior staff nurse and loved her work but retrained as a health visitor in response to problems in combining parental and working responsibilities.

<sup>18</sup> State Enrolled Nurses (SEN) were introduced as 'second level' nurses by the Nurses Act of 1943. They received two years training as pupil nurses rather than the three completed by student nurses training to become RGNs. This second level training is no longer offered and, although many nurses continue to practice as SEN's, they are encouraged to attend conversion courses to become Registered Nurses (RNs), the qualification that has replaced the RGN.

Table Three : Overview of Participants					
Pseudonym	Age group	Speciality and grade	Dependants	Practice and breaks	Biographical notes
David	30-40	G grade specialist in a category 2 hospital department.	Father of young children	Practising F/T  One break from practise of four months due to illness.  Has thought of leaving due to the 'power games' in nursing.	Lived in Canada as a teenager. Worked in a health project there over one summer. Returned to England and trained as a nurse. Worked in various specialities including theatres. Took a degree in nurse education and moved to hospice nursing. Now a specialist nurse
Eileen	40-50	E grade community staff nurse <sup>19</sup>	Mother of teenage children	Practising F/T  18 month break when her children were born.	Trained as a nurse on leaving school. Worked in various areas including treatment room, day hospital, community bank and as a store nurse for a supermarket chain.
Elizabeth	30-40	Full time mother	Mother of one pre-school and one primary school aged child	Not practising.  No intention of returning to the wards unless there are substantial changes allowing her to work safely and holistically.	Completed degree in psychology and 'worked with handicapped people' before training as a nurse. Had several bad experiences as a staff nurse but persisted until her children were born. Now sees motherhood as an expression of her commitment to caring
Emma	40-50	H grade hospital based manager in a category 1 department.	No dependants	F/T manager.  No breaks during practice	Trained as a nurse on leaving school. Worked her way up to the level of charge nurse. Moved to nursing development <sup>20</sup> and then management.

<sup>19</sup> As a community staff nurse Eileen works as part of a district nursing team.

<sup>20</sup> Emma's move to nursing development involved moving off the wards into work aimed at improving nursing practise in her Trust, e.g. auditing nursing standards and developing better discharge planning procedures.

<b>Table Three : Overview of Participants</b>					
<b>Pseudonym</b>	<b>Age group</b>	<b>Speciality and grade</b>	<b>Dependants</b>	<b>Practice and breaks</b>	<b>Biographical notes</b>
Frances	30-40	Category 1 hospital nurse.  Split post on the same ward,  E grade staff nurse/ F grade clinical development co-ordinator.	No dependants	Practising F/T  No thoughts of leaving.	Graduate nurse.  Spent some time travelling overseas but worked as a nurse during this period.
Gemma	30-40	Category 1 hospital nurse.  G Grade Clinical Development Co-ordinator <sup>21</sup> .	Mother of a small child	Practising F/T.  Took minimal time out for maternity leave.	Entered nursing on leaving school. Graduate nurse with a Masters degree. Experience in nursing research. Worked as a specialist nurse in the department where she is now clinical development co-ordinator.  Sometimes thinks of leaving but is not planning to do so.
Heather	30-40	H grade community manager.	No dependants	F/T Manager.  No breaks in practice	Graduate nurse.  Worked in a 'high tech.' hospital speciality before training as a health visitor. Later moved into management.  Contemplated leaving at the end of training and again during a difficult period as a health visitor. Decided to stay.

<sup>21</sup> As a clinical development co-ordinator, Gemma is responsible for providing support and guidance for new nurses in her department, for identifying the training needs of the whole nursing staff, and for organising the placement of nursing staff on training courses. In this role she works alongside ward based nurses providing support and guidance as well as fulfilling a more managerial role as co-ordinator.

<b>Table Three : Overview of Participants</b>					
<b>Pseudonym</b>	<b>Age group</b>	<b>Speciality and grade</b>	<b>Dependants</b>	<b>Practice and breaks</b>	<b>Biographical notes</b>
James	30-40	G Grade specialist nurse and nursing lecturer	No dependants	F/T in joint post. No breaks in practice.	Trained as a health service administrator but decided he wanted more patient contact so completed a degree in nursing. Worked as a staff nurse in hospitals and then as a charge nurse. Moved to nursing research after a difficult period on the wards. Now has a joint post as a specialist nurse and nursing lecturer.
Jane	20-30	Category 1 hospital nurse. D grade staff nurse	No dependants	Practising F/T No breaks in practice but definite plans to leave nursing.	Graduate nurse who initially wanted to be a doctor but lacked confidence in her academic abilities. Gained confidence during training and has now secured a place to study medicine next year.
Jean	30-40	Sheltered housing warden	Mother of one primary school aged child. Stepmother of one school aged child who does not live with her.	Break from practice for maternity leave. Left nursing with no intention of returning	Completed a degree in social policy and worked in various caring jobs before training as a nurse. Worked as a hospital staff nurse before training as a district nurse. Left when she felt changes in her workplace prevented her from providing patient centred care.

**Table Three : Overview of Participants**

<b>Pseudonym</b>	<b>Age group</b>	<b>Speciality and grade</b>	<b>Dependants</b>	<b>Practice and breaks</b>	<b>Biographical notes</b>
Judy	40-50	G grade district nurse.	Mother of four school age children	Practising P/T in a job share.  Left nursing early in career and then returned.	Left school at 16 and worked in various jobs before completing a pre-nursing course and then trained as a nurse. Left nursing for a while because she disliked 'hospital culture'. Worked for a hospice before returning to train as a district nurse. Four breaks for maternity leave since that time.
Karen	30-40	Category 2 hospital nurse.  F Grade staff nurse and has 'acted up' as charge nurse twice.	No dependants	Practising F/T.  No plans to leave. No breaks in practice.	Trained as a nurse on leaving school.
Kate	20-30	Category 1 hospital nurse.  G grade specialist	Mother of a small child	Practising F/T  No breaks in practice except maternity leave.	Trained as a nurse on leaving school.  Funded her own nursing degree studies, combining this with F/T work and a new baby. Secured specialist nurse post after completing degree.
Lesley	30-40	Runs her own business that has no connection with healthcare.	No dependants	Left nursing with no plans to return.	Initially wanted to be a doctor but chose nursing instead. Worked as a staff nurse and then as a research project nurse before becoming a charge nurse and then a specialist nurse. Left due to lack of career opportunities and support.



<b>Table Three : Overview of Participants</b>					
<b>Pseudonym</b>	<b>Age group</b>	<b>Speciality and grade</b>	<b>Dependants</b>	<b>Practice and breaks</b>	<b>Biographical notes</b>
Lindsay	30-40	G grade school nurse.	Mother of one pre-school and one primary school aged child.	Practising F/T.  Two breaks for maternity leave.	Trained as a dental technician before training as a nurse and specialising in theatre nursing. Experienced problems combining work and motherhood and almost left nursing completely but moved to school nursing instead
Liz	40-50	H Grade hospital based manager for a department in category 2.	No dependants	F/T manager  No breaks in practice as a nurse except for 18 months spent in midwifery training.	Trained as a nurse on leaving school. Charge nurse for several years before applying for her current post as a manager 18 months ago.
Margaret	30-40	Category 2 hospital nurse.  E grade staff nurse	No dependants	Practising F/T.  Planning to leave nursing.	Worked in a variety of jobs before becoming a care assistant in a hospice. Persuaded by a senior colleague to train as a nurse. Graduate training followed by a Masters degree. Planning to move to a new post before marrying and leaving nursing completely.
Maria	20-30	Category 2 hospital nurse.  E Grade staff nurse	No dependants	Practising F/T.  No breaks in practice.	Entered nursing on leaving school. Graduate nurse.  No serious thoughts of leaving despite difficult experiences.

Table Three : Overview of Participants					
Pseudonym	Age group	Speciality and grade	Dependants	Practice and breaks	Biographical notes
Mark	20-30	Social work student	No dependants	Left nursing with no intention of returning	Trained as a nurse on leaving school. Moved from another city due to unhappiness in post. Worked as E grade staff nurse and combined this with studying for a counselling diploma. Left nursing to study for a degree in social work as he couldn't face the pressures involved in combining work as a nurse with study for a nursing degree.
Mary	40-50	D grade SEN Category 2 hospital nurse	No dependants	Practising F/T No breaks in practice.	Trained as SEN but now experiencing pressure to train as an RN. Unhappy about this but enjoys her work.  Considered leaving when her ward was transferred to a new hospital but found the prospect too frightening.
Robert	40-50	G grade health visitor	Father of one child and has dependent parents.	Practising F/T. Spent a year working in a project for the homeless and four and a half years in a community health project.  No thoughts of leaving at present unless a particularly tempting opportunity arises.	Worked in various jobs before completing a degree in biology and psychology. Trained as a nurse and worked in various specialities before training as a health visitor.  His 'breaks' from nursing have not taken him far from his role as a health visitor which he sees as a form of community work.

<b>Table Three : Overview of Participants</b>					
<b>Pseudonym</b>	<b>Age group</b>	<b>Speciality and grade</b>	<b>Dependants</b>	<b>Practice and breaks</b>	<b>Biographical notes</b>
Ruth	40-50	H grade community manager	Mother of unknown number of children	Practising F/T  Took a year out when her first son was born.	Ruth's interview was curtailed due to illness so my knowledge of her career and background are limited.  Worked in retail for a short period after leaving school, then trained as a nurse.  Worked on the community bank P/T after her son was born then trained as a district nurse. Later moved to management.
Sue	40-50	Category 2 hospital nurse. G Grade charge nurse	Mother of two teenage children	Practising F/T  Took a break for several years when her children were born during which time she worked as a classroom assistant.	Completed a degree in sociology before training as a nurse.  Considered health visiting but has remained in hospital nursing
Valerie	40-50	Complementary therapist	Mother of adult children	Left nursing with no plans to return.	Trained as a nurse in the USA. Worked in clinical practise and management before moving to Britain where she worked as a manager in a hospital. Left nursing when she felt that the circumstances at work prevented her from doing her job well.

### *The Racial Origins of Participants*

Twenty-six of the people participating in this study were British, one was Irish and one was American. All of the participants were white. This was not a deliberate choice but rather reflected the racial profile of nursing in Edinburgh. Furthermore,

during the period of recruitment I did not meet any overseas nurses and none volunteered for the study. Although there are a large number of racial groups within the city, including a sizeable Asian population, they are not well represented within the nursing workforce. There is a body of literature that addresses this issue, pointing to the barriers to entering nursing within Asian cultures in particular (e.g. Swinburne, 2000). However, there is also the issue of racism reflected in the discourse, and therefore the structures and practices, of British nursing, and in the choices made when selecting potential recruits (Hugman, 1991; Baxter, 2002). The overwhelmingly white profile of nursing in the city is likely to be the product of a complex set of interconnected factors.

The absence of participants from other racial groups is one of the weaknesses in this study. In other parts of Britain there are many black British nurses and others from different racial groups. It may be that their ideas about nursing differ from those of white British nurses or they may share their white colleagues' perspectives. Research into the differences between different racial groups' understanding of nursing, and the impact of the introduction of large numbers of overseas nurses, would provide a valuable contribution to our understanding of the nursing workforce.

#### *The Gender Profile of Participants*

No practising male nurses volunteered from any of the hospital departments targeted and so I had to actively search out willing male volunteers through my own nursing contacts in the city. I eventually managed to interview one man who had left nursing, one who was working in the community and two in hospital posts. One of the latter two was a part time lecturer and the other was combining nursing with a postgraduate degree.

The number of men participating in this study is small but reflects the percentage of men within nursing nationally which stood at 10.9% in England (DoH, 2005b) and 10% in Scotland (Scottish Executive, 2005a) in 2004. Despite the small number, it soon became apparent that these men do not fulfil the stereotype of male nurses as being more interested in technical nursing than in communication and relationship building. Each of them stresses the central role that communication has within nursing and none are working in highly technical areas. Their perspectives are

notable for their similarities with those of the female participants more than the differences, an observation that has also been made by Mackay (1989: 37). On the basis of this study it is not possible to make any claims about different discourses across the gender divide, but these examples suggest that this is also an area that deserves further exploration.

### *Participants' Diversity of Experience*

Instead of viewing each participant as an isolated individual representing a group of similar individuals, I approached them as people whose socialisation into, and experience of, nursing reflects the perspectives of the many nurses with whom they have come into contact. Although the practising nurses in this study were recruited from only two Trusts operating in the same city, several had worked in a number of other cities and some had experience of working in England and other countries beyond the UK. The high turnover that characterises nursing also ensured that most had worked in more than one speciality. The experiences of participants include paediatrics, theatre nursing, orthopaedics, school nursing, urology, hospice work<sup>22</sup>, general medical and surgical nursing, gynaecology, midwifery<sup>23</sup>, coronary care, gastro-intestinal nursing, palliative care and care of the elderly. One participant had even worked as an occupational health nurse for a supermarket.

During these varied experiences, participants will have interacted with an enormous number of other nurses. As a student, each participant will have spent a few weeks in ten or more hospital wards and departments as well as spending time with various community-nursing specialists. As staff nurses they will have changed post on several occasions. In each work place they will have worked with a team of nurses that may or may not have remained the same for the duration of their stay. For example, as a student, I began a particular placement with one sister who was replaced by another after two or three weeks. By the time I finished my eight-week placement, a large proportion of the staff had changed. Added to this are the large number of agency and bank staff and the tendency for hospital

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<sup>22</sup> In Britain, hospices are funded by charitable organisations and are not part of the NHS.

<sup>23</sup> Midwifery is not a branch of nursing but the person involved had trained as a midwife in order to progress in her chosen speciality of gynaecology. Conversely, until the 1980s midwives were required to train as nurses first.

managers to move nurses from one ward to another in order to provide cover for sickness or even for dinner and coffee breaks. When the circle of nursing friends and acquaintances that a nurse builds up in the course of her career is taken into account, it becomes clear that each participant has an enormous reservoir of interactions with other nurses upon which to base her understanding of nursing.

In addition to a consideration of the numbers of nurses included in this study, there is also the question of whether I have only interviewed people who are passionate about nursing and want to talk about it. To what extent have I overlooked a potentially large group who, in Peelo et al's terms (1996), see nursing as 'just a job' and do not share participants' enthusiasm? To some extent this study is limited by the absence of nurses who 'don't care'. However, it is neither possible nor ethical to force people to participate if they are unwilling. This is a problem faced by any research project and has to be borne in mind when reading this thesis. Despite this limitation, it is possible to gain some idea of whether participants in this study are unusual in their enthusiasm for nursing. First, the level of interest in this study shown by the nurses and people connected with healthcare that I have spoken with has been enormous. As I describe above, at times the recruitment meetings felt more like focus groups and I struggled to keep the attention of those present on the subject of the study. I have also presented my work to other nurses and healthcare workers at three conferences. On each occasion the presentation was followed by intense debate that overflowed into the coffee and lunch breaks that followed. I felt each time that I had struck a chord and the healthcare professionals present clearly shared participants' passion and frustration. Second, annual membership surveys conducted by the RCN show that the percentage of respondents expressing enthusiasm for their job has risen from 74% in 2000 (Ball and Stock, 2000: 49), to 80% in 2005 (Ball and Pike, 2005:78). This suggests that, far from being restricted to a small minority, an enthusiasm for nursing characterises much of the workforce.

## ***Interviewing***

### *Interview Locations*

I offered participants a variety of options for the location of the interviews. The choice was left entirely to them. I was aware that several participants needed to fit their interview in before or after a shift and so the venue needed to be conveniently

close to their place of work. Some chose a quiet place on their ward while others opted to come to the facilities provided by the Wellcome Fund within one of the hospitals. This enabled them to maintain their anonymity. Most of the community nurses and some of the ex-nurses chose my office as a convenient and quiet place that also offered anonymity. Some of the ex-nurses invited me to their homes. In offering this range of alternatives I was aware of the effect of the environment on an interaction. As a community nurse I was particularly conscious of the way in which people's confidence in an interaction is heightened when they are on their own territory whether at home or in their place of work.

### *Interview Structure*

In order to understand nursing from the perspective of nurses themselves, I deliberately took a very loose approach to structuring the interviews, allowing participants to identify the areas that they considered to be most important. In order to ensure that they remained within the boundaries of the study I began each interview by recapping the purpose of the interview. I also used a topic guide that served as a personal reminder of the areas I wished to explore with each participant. This enabled me to bring participants back to these areas when they moved into unrelated areas. As my analysis developed the topic guides changed to allow me to explore new areas of interest and to tailor my questions to the individual participant's situation. Throughout the interviews, and later as I analysed the transcripts, the basic questions that I asked myself were:

- What does this person think that nursing is?
- How do they expect themselves and their colleagues to behave as nurses, particularly when they are unhappy or under pressure?
- What do they give to their work and what do they get back from it?
- What is this person's orientation towards the idea, or experience of leaving nursing?

However, the questions that I asked participants were less specific. I wanted to identify the assumptions and expectations that lay behind their reflections. I therefore asked broad, open-ended questions that encouraged participants to talk generally about their working lives, and that avoided introducing words that reflect particular discourses. For example, I consciously avoided talking about nursing as

a profession or a vocation in order to see whether participants would draw on these strands of the discourse of nursing themselves. I found that, contrary to the assumptions made by previous researchers (e.g. Williams et al, 1991), these are not concepts that shape nurses' thinking about staying in or leaving nursing. Furthermore, the ways in which participants use these words demonstrates that they can be understood in a variety of ways that sometimes conflict with the definitions presented in nursing textbooks.

In each interview the topic guide served as a prompt on the rare occasions when the flow of conversation ended. The guides changed with each interview as I sought to explore new areas, and to offer the accounts of previous participants as food for thought. However, I retained three key questions throughout that gave structure to the interviews and stimulated particularly rich responses.

I began each interview by asking for a précis of the individual's career, and in many cases this led to an explosion of thoughts, feelings and experiences on the subject of nursing. I then picked up on areas that seemed to be particularly relevant and prompted participants to explore these in greater detail. This first question helped me to understand the shape and course of participants' careers and so situate my questions within their particular experiences. It also allowed participants to begin slowly with factual details, and to move into deeper reflections and more personal material when they felt comfortable in doing so.

The second question that I asked in each interview was 'Do you have any role models?'. This encouraged participants to talk about people whom they believed to be good nurses and attempted to emulate. Their answers provided rich material for analysis in two areas. First, their descriptions of role models indicate both their own and wider occupational expectations of how nurses should behave, the kind of person a nurse should be, and the attributes she should possess. Second, their criteria for a 'good nurse' revealed their underlying assumptions regarding the purpose of nursing, the form it should take, and the way in which nursing care should be organised and delivered.

In most of the interviews I finished by asking 'Can you give me an example of a situation that you have been involved in that sums up nursing for you?'. This question was interpreted in two ways. Some participants chose to answer it in terms of the function of nursing and the role of the nurse; indeed this was the



meaning that I had intended. However, most used it as a starting point for reflecting on the rewards of nursing, offering experiences that had highlighted for them the reasons why they continued in nursing. In phrasing my question in an ambiguous way I inadvertently tapped into a rich vein of material. This question proved to be such an effective trigger of stories that I did not change the wording when I realised the ambiguity it contained. It also served as a useful reminder of the extent to which the meaning ascribed to an utterance reflects an interaction between the speaker and recipient. The meaning behind the question changed in my mind in response to participants' interpretation of it to the extent that in the later interviews I was surprised when participants responded in terms of the function of nursing.

### *Interview Approach*

My experiences as a nurse in both hospital and community settings have been formative in my approach to interviewing participants in this study. As a nurse, I learned the interview skills necessary to admit a patient to a ward and make an initial holistic assessment of their condition and circumstances. The initial assessment of a patient is a complex and intense example of communication between two or more people. As a student nurse I learned how to draw out a large amount of information from a person within a short period of time. Although there were certain details that the healthcare team needed in order to develop a care plan for the person concerned, I also needed to know how the person understood and felt about her situation in order to support her through the initial stress of being admitted to hospital. Sometimes I needed to include an element of teaching, and the person always needed to be informed of the layout and routines of the ward and to have her vital signs checked. Throughout the interaction I needed to lay the foundations of trust that are essential to an effective nurse/patient relationship. This was all completed within a very short space of time, usually less than twenty minutes. The communication skills that I learned as a nurse enabled me to work with participants in ways that produced rich and complex accounts of their thoughts and experiences within a relatively short space of time.

As a community nurse, carrying out annual health assessments for people over the age of 75, I developed these skills further. Time was less pressured but I needed to

allow the person concerned to tell me which aspects of her life were creating problems for her. I found that instead of using a simple checklist, it was more effective to prompt the person to talk generally about her health and ability to care for herself independently. In this way I could identify the issues that were most important to the client, and focus on them instead of wasting time with a list of questions that were often irrelevant. The checklist became a prompt at the end of the interview to ensure that we had not missed anything. In conducting research interviews I found myself using a very similar approach. Often I did not use the topic guide until the latter stages of the interview, allowing participants to identify for themselves what were the most important issues for them.

Another dimension of my experience that contributes to my interview style is my training in counselling skills. The lack of previous research in this area, and the fact that many participants had not often had the opportunity to discuss their working lives before, meant that this was not simply an exercise in obtaining answers to a set of questions. In the interviews I drew on the ideas of Carl Rogers who emphasised the importance of allowing the person being counselled the freedom to explore their own ideas and experiences and develop their own understanding with the help and support of the counsellor (Rogers, 1961). As Mullings argues in the context of the research situation (Mullings, 1999), in order to achieve this, the counsellor has to position herself relative to the counselees in ways that enable them to find safe spaces in which to explore their thoughts and feelings.

Within the context of research rather than counselling, Bourdieu argues in favour of this reflective and loosely structured approach to interviews:

The real bases of the discontent and dissatisfaction expressed ... can only be brought to consciousness – that is to explicit discourse – where an effort is made to bring to light these things buried deep within the people who experience them – people who are both unaware of these things and, in another sense, known them better than anyone. (Bourdieu, 1999: 621)

For Bourdieu, the researcher is a ‘midwife’ who helps the interviewee to bring these deeper understandings to birth, a skill that depends upon the researcher’s deeper understanding of the context within which the interviewee develops her understanding (ibid.). This maieutic approach to interviewing is consonant with the idea of the interview as a joint enterprise in which researcher and participant work together to find meaning in the topic being discussed (for a consideration of

the debates in this area see Holstein and Gubrium, 1995; Fontana and Frey, 2000; Ellis and Berger, 2002).

In drawing upon my education in the social sciences, in reading widely within the nursing and healthcare literature, and in drawing upon previous participants' accounts I sought to fulfil the role of midwife. I tried to create a space in which participants could reflect upon and develop their understanding of nursing and in so doing I drew upon the counselling skills of active listening, empathy and unconditional positive regard (e.g. see Mearnes and Thorne, 1995). As a researcher I tried to find a balance between using my own perspective and experiences to facilitate our communication and deepen the analysis, and holding back in order to ensure that it was the participants voice and not my own that dominated the interview.

#### *The Question of 'Truth' in Participants' Accounts*

As I was engaged in understanding individuals' perceptions, I had to ask myself whether their responses genuinely reflected their thoughts and feelings, and take into account the fact that I was only hearing one interpretation of the events and conversations they described. In some cases, the presence of several people from one department enabled me to compare different perspectives on the same events. As someone who has trained and worked as a nurse in Edinburgh I was also able to contextualise participants' accounts within my own knowledge of the people and organisations involved. As a fellow nurse my own knowledge and experience of nursing enabled me to exercise professional judgement in deciding whether participants' accounts were plausible. In addition to these approaches to judging the truthfulness of participants' accounts I paid close attention to the intensity of their speech and body language. Again, my status as a nurse and, therefore, as a person who has both training and experience in human communication, was invaluable. On one occasion I did question the truth of a participant's account. I was uncomfortable with her interview and it crossed my mind that she might not actually be a nurse. Although there was no clear evidence that she was anything other than what she claimed to be, on this basis, and on the advice of my supervisors, I decided to omit her account.

### *Ethical Considerations in Interviewing Participants*

Earlier in this chapter I explore concerns arising from the imbalance of power between researcher and participant and the potential for research to perpetuate existing patterns of domination and oppression. My position in this respect is complex in that, as a nurse, I share the experience of belonging to an occupational culture that has developed within a subordinate relationship with medicine. However, as a researcher I am also in position of power, both in the interview situation and in that I am the one who writes the final analysis, presenting participants' accounts to the reader.

During the interviews I was aware that my training in communication skills in general, and counselling skills in particular, gave me considerable power to draw out information from participants that they might later wish they had not shared. I was aware of the sensitive nature of many of their experiences and the possibility that they would find the interview traumatic and so I made it clear before the interviews began that participants were free to stop their interview at any time, or to refuse to answer questions that they found too personal.

In most instances there were no problems, but Ruth did end her interview prematurely, as I describe in chapter five. I also formed the impression that Sue did not wish to talk about her more personal feelings regarding her experiences with patients, and so I was careful not to push too hard into these areas. In her interview we focused more on her thoughts about the organisation and politics of nursing, a subject that proved to be very fruitful. Although some participants did weep as they recounted their experiences, they also expressed their pleasure at being able to talk, and the interviews seemed to have a positive cathartic effect. One participant later informed me that the interviews had triggered a great deal of discussion in her department and so seem to have had the positive effect of expanding the opportunities for this small group of nurses to talk (research diary, 2002).

In this section I have traced the generation of the texts that reflect individual nurses' thoughts and experiences from the selection and recruitment of participants, through to their interviews. In the following section I turn to the selection of published texts that provide a context for these individual accounts.

### Selecting Published Nursing Texts

Although the twenty eight transcripts reflect the perspectives and actions of a large number of nurses, I needed a wider selection of texts in order to find how these perspectives relate to broader nursing discourse. In order to make the links, I needed texts that had been created by nurses beyond the circle of participants' acquaintances. I found these in nursing textbooks, in journal articles and research papers written by nurses, and in the letters pages of nursing magazines. Nursing textbooks provided examples of nursing discourse that are an essential part of the socialisation of new generations of nurses. Their acceptance as teaching aids indicates the extent to which they represent the dominant strands of discourse operating within the sphere of nurse education. Research papers often include descriptions and interpretations of nurses' attitudes and behaviour that provide a wider context within which to view the accounts of individual participants in this study. Although some provided useful support for my analysis, while others challenged me to rethink certain areas, I did not consider these papers as definitive statements of reality. Instead I approached them as expressions of nursing discourse and subjected them to analysis alongside the other texts. The letters written by nurses to their professional journals and magazines offer insights into the ways in which practising nurses engage with the debates and understand their working lives. Finally, I also included the NMC's *Professional Code of Conduct* in my analysis since this document codifies dominant aspects of the discourse of nursing, into a formal and enforceable code, expressed in the language of professionalism. This is particularly important since nurses' experience and understanding of their work is not purely a matter of ideas and opinions. Regardless of whether nurses subscribe to the idea of nursing as a profession, it is imposed upon them in the form of rules and regulations that circumscribe their behaviour. To some extent, *The Code* expresses nurses' general expectations of each other, but the form that it takes strongly reflects the 'professional' emphasis on accountability in the application of professional knowledge. As such, it offers insights into the ways in which powerful groups within nursing have imposed their perspectives on the rest of the occupational group.

## Selecting Non-Nursing Texts

In addition to these nursing texts I also needed to analyse texts produced by non-nurses that pertain to the broader context of the NHS and the political economy of nursing. Although I have placed great emphasis on the importance of discourse, it is also important to recognise that nursing does not exist in isolation from the rest of the world, and that nurses are not free to construct nursing in any way they choose. For example, in chapter four, Emma complains that junior nurses do not understand that she cannot fill posts that do not exist. She does not command the resources or have sufficient authority within her Trust to translate nurses' ideas about establishment figures into concrete realities. In chapter three, the conflict between nurses' ideas about how nursing should be organised and resourced, and the constraints imposed upon them by the system in which they work is particularly apparent. Their access to resources is shaped by both the economic ideas of policy makers and managers and the concrete situation that these ideas have created.

The way in which nursing is organised is strongly influenced by non-nurses' understandings of the function of nurses and the ways in which these ideas translate into the realities of NHS structures and systems as well as training policies and curricula. For example, recent policy papers reflect a move towards integrated training and the development of generic healthcare workers as an alternative to the clear boundaries and divisions between current professional groups (DoH, 2000; Scottish Executive, 2000). These proposed changes have not originated within nursing but will have a profound impact upon its future. The roles of nurses participating within this study also reflect the policy decisions made beyond the boundaries of nursing. For example, attempts to improve the career structure for nurses have led to the creation of specialist posts held by some of the participants. Nurses have then adapted and changed the role according to their own ideas, creating a series of debates as to the 'correct' interpretation of these new roles (e.g. Torn and McNichol, 1997; Williams and Sibbald, 1999).

In these examples, the impact of the broad, political economy of nursing appears within participants' accounts. However, to situate these accounts more securely in their context, I also needed to include texts written by non-nurses that illuminate the political economy of nursing further. I found these in policy documents, in

news reports and commentaries, in documents and websites created by organisations representing patients and other groups, in magazines, in non-nursing research papers and books and in televisual and radio representations of nurses and nursing.

### **The Criteria for Selecting Texts**

Throughout the study I read widely and eclectically in order to gather as many different perspectives on nursing and nurses' responses to dissatisfaction as possible. I conducted computer searches for material in libraries and on websites according to the themes that arose during the analysis. I systematically checked healthcare journals each month and contacted organisations such as the RCN with requests for assistance. However, no matter how systematic my searches, the enormous wealth of texts relating to nursing meant that it was neither possible to collect them all, nor to create a random sample. The choice of texts is inevitably shaped by their availability and, to a certain extent, by chance (McGrath, 1996). Many texts were identified for me by colleagues, friends and family who found them in the course of their work or daily lives; others I found by chance while browsing in libraries, reading the papers or watching the news. Allowing time for the opportunity to make such chance finds is a strategy that is advocated by Glaser and Strauss (1967). Rather than constituting a representative sample, these texts provide a diverse spread of perspectives and opinions that enabled me to look for both convergence of opinion and for contradiction, a key aspect of validity within the interpretivist tradition (Lincoln and Guba, 2000; Riessman, 1993; Glaser and Strauss, 1967). Their value lies not in their accuracy or truthfulness but in the insights that they offer into the discourse of nursing. The purpose of theoretical sampling is to achieve diversity rather than verification so my choices were made on the basis of texts' relevance to the developing theory (Glaser and Strauss, 1967). Consequently the processes of text selection and analysis were iterative and interconnected. While some texts were useful in their support for my ongoing analysis, the challenge posed by others required me to review and adapt my analysis. Given the vast quantity of relevant literature I had to set a limit to the collection and analysis of texts. Once again, Glaser and Strauss (1967) provided a rationale for this decision in the concept of saturation. I stopped the search for new

material when the content of my reading became repetitive and provided no new ideas. However, this saturation point was not definitive and, as I refined the thesis, I continued to incorporate new texts as I came across them. This continuation of collection and analysis reflects the provisional and fluid nature of any interpretation as I describe earlier in the chapter. Ultimately, the final decision to end was determined by the need to submit a thesis within the proscribed time limits.

### **THE PROCESS OF ANALYSIS**

Since my approach to analysis is hermeneutical, this process occurred simultaneously with those of collecting material and writing the thesis. However, for the purposes of this thesis I have divided the process into an artificial series of discrete stages. In reality these stages overlapped and intersected since I interviewed some participants in between transcribing the interviews of others and writing provisional analyses. In the following section I describe the process of analysis, combining a chronological strand, that moves from interviewing through transcribing to writing the thesis, with a strand that moves constantly back and forth between a concern with individual participants, with the combined transcripts and with NHS nursing as a whole.

### **Analysing and Interviewing**

My analysis of individual participants' accounts began in the interviews, during which I sought to make sense of each participant as a person, teasing out his or her ideas of what the role of a nurse is, and of how nurses should and should not behave and whether or not leaving is an acceptable option. I looked at the part that nursing plays in each individual's life, asking myself whether it is a part of personal identity or simply a role that is played at work. I looked for each participant's understanding of the boundaries of the nurse's role and what counts as 'leaving', a question that is particularly relevant for those participants who have moved into health visiting or management. With those who had left nursing, or who had considered this course I searched for indications of the attitudes of their colleagues, friends and families towards their decision to leave. In so doing I sought to



contextualise their experiences and feelings and to understand the influences that had shaped them.

### **Analysing and Transcribing**

As I listened to the tapes of the interviews, certain passages that I had not paid attention to before took on a new relevance, sparking new ideas or altering my previous understandings. In transcribing a conversation, the transcriber creates a text that reflects her own interpretation of the interaction and not a simple reproduction of what was said (Riessman, 1993). She inevitably pays more attention to particular areas and omits others, and for this reason I transcribed all of the tapes myself. I chose to use straightforward word processing software rather than a computer programme designed for qualitative research. The version of the latter available at the time confined transcripts to 'simple text' format and this would have prevented me from including the rich non-verbal aspects of our communication. Since discourse manifests itself in non-verbal as well as verbal ways, I formatted the text to indicate these non-verbal aspects of the interviews. In the transcripts, words that carry particular emphasis are italicised, changes in the direction of a sentence are marked by ... , a pause is indicated by (...) and other non-verbal sounds are described in parentheses e.g. (laughs), (sighs). I supplemented this formatting with comments that allow the insertion of more specific details regarding participants' accounts and my own responses and thoughts at the time. At times I struggled to hear the words when the tapes distorted or background noises interfered. I then had to recreate the words, relying on the context, notes I had made during the interview, and my memories of what had been said. As the transcriber, the choices I made regarding punctuation also shaped the meaning conveyed by the text.

### **Analysing the Transcripts**

#### ***Understanding Participants as Individuals***

The third level of analysis occurred as I read and tried to make sense of the transcripts. As I studied each one I developed a profile for the participant that included her biographical details as well as the main themes within her transcript. The fluid nature of the interviews meant that biographical information was often

scattered throughout and had to be reconstructed. In our explorations we had moved between topics, returning to previous areas to make links or change interpretations. In developing an overview I was able to make more sense of the transcripts and identify links or contradictions that had not been apparent before. These texts represented my understanding of participants as whole and complex people, with subtly different understandings of what it means to be a nurse, and perspectives on the possibility, acceptability and experience of leaving nursing.

### ***Comparing and Contrasting Participants' Accounts***

To balance this narrow focus on individual participants, I compared the transcripts, looking for both the commonalities and the differences. Instead of looking at each person as a whole, I broke their transcripts down into a series of chunks and sorted them into theme files. In so doing I created a new series of texts for analysis, which reflected my own interpretation of what is and is not relevant. The creation of these new texts enabled me to see which themes recur across the group. Since I organised the files in such a way that conflicting opinions on the same subject were grouped together I was able to see the contradictions and conflicts surrounding these issues clearly.

Having organised all of the material into these files I transferred the headings of the theme files that I had created into a series of index cards, which I gathered into related groups and arranged in patterns that reflected the connections between the groups. When I was satisfied that the arrangements flowed and made sense I used them to guide my writing.

As I analysed the texts that originated in the interviews, I moved between a focus on individual transcripts as reflections of whole people, and the theme files that indicated the discourses upon which participants had drawn. This approach often clarified my thoughts and helped me to move on when I became stuck. In moving between an analysis of individual participants and a comparison of the accounts I was able to begin identifying common themes and sources of conflict. I also paid particular attention to those accounts that conflicted with my own thoughts and experiences as they helped me to identify and explore my own assumptions about nursing.

### ***Contextualising the Transcripts Within Broader Debates***

By moving between an analysis of individual accounts and of the transcripts as a group, within the context of other nursing and non-nursing texts, I was able to connect the details of isolated accounts in to the broader context that shaped them. The issue of strength and weakness among nurses provides a good example of this. A single expression of the fear of being seen as weak could be interpreted as the isolated idiosyncrasy of one nurse. However, within the context of a series of similar expressions, and of other instances in which participants stressed the importance of strength, this became a focus for analysis. When considered with other nursing texts, these shared fears can be seen as part of a strand of discourse in British nursing that equates good nursing with physical and emotional strength. When viewed in the context of the political economy of nursing, this particular strand of nursing discourse can be connected into other discourses of work and gender that exhibit a moral condemnation of physical and emotional 'weakness'. For a more detailed examination of this aspect of the analysis see chapter five.

### **Analysing and Writing**

Throughout the phase of gathering material for analysis, and until the final draft of the thesis was written, I reflected on the contents of the transcripts and their relationship to wider discourses in my research diary. I developed my ideas further by writing several papers around the themes that I identified. The process of writing helped me to clarify and connect the ideas that I generated and to deepen the analysis. For example, after attempting to write the first draft around the concepts of nursing as a profession, a vocation and a job I realised that the reason why the ideas did not flow was that these were not key ideas used by participants and I was imposing a categorisation upon their views that did not fit. Instead I turned to the concept of commitment as one of the main themes running through participants' accounts. After completing the first draft I realised that, while this is an extremely important concept, it does not provide a framework that will carry the entire thesis. On re-reading the draft it became clear that the concept of negotiating boundaries was also a powerful theme. When used as a framework this concept

enabled me to explore issues of power and conflict in ways that had not been possible before

In the following section I move from a concern with the analysis to a description of the writing of this thesis. Although this aspect concludes my description of the research process, in reality, as I describe above and as King and McGrath (2004) also note, writing is an integral part of the whole analytical process. The production of the final thesis was more a matter of weaving together pieces that have been written at various times and as part of other papers, with new passages, than of finishing the analysis and then sitting down to write up the results. In this way the analysis continued through the process of editing until the very end.

### **THE PROCESS OF WRITING THE THESIS**

In this section I move away from the analytical dimension of writing to consider the choices that I made regarding the way in which I presented my analysis. I describe the means by which I made myself and the participants present in the thesis as real people rather than detached observers or anonymous voices. In this I include a consideration of the ethical issues involved. The chapter concludes with a consideration of the way in which the structure of the thesis relates to the particular research approach that I have taken.

#### **The Presence of the Author**

The approach that I have taken to this study reflects the interpretivist position that it is not possible for a researcher to remain detached and objective when studying social phenomena. This position requires that the researcher should engage reflexively with the research process and provide the reader with sufficient information to allow her to make her own judgement of the worth of the findings. In order to achieve this I have sought to make myself present in the thesis by using the personal pronoun throughout. I include a small number of examples from my own personal experiences in the text and these serve a dual purpose. First, self-reflection has been an essential tool, enabling me to separate out my own feelings from those of the nurses participating in this study; second, in including references to myself as a nurse I remind the reader of my own involvement in the issues discussed.

## **Representing Participants' Views**

Since one of my original intentions was to write this thesis in such a way that the voices of the nurses participating in the study would come through strongly, I have included substantial chunks of the interview transcripts. In some cases I have altered these to preserve the anonymity of the person concerned. The reflective nature of the interviews, and the way in which many participants developed meanings as they voiced their thoughts led to some parts of the transcripts being difficult to follow. Therefore, I have removed some of the instances in which participants have stopped part way through an utterance to rephrase a sentence, or used words and sounds that do not obviously add to the meaning conveyed. In other instances I have left the chunks intact, complete with pauses, confused words and sounds, and unfinished sentences because these aspects of the accounts provide clues as to the participant's state of mind or meaning. For example, long pauses often conveyed the difficulty that participants experienced when reflecting on traumatic experiences.

The chunks presented do not provide a direct representation of participants' thoughts and feelings. Indeed, some participants may disagree strongly with my analysis of their interview. As Riessman argues, there are many layers of interpretation and reinterpretation involved when one person presents the thoughts, feelings and experiences of another to a third party (Riessman, 1993). As I argue above, in transcribing the interviews I shaped the meaning conveyed to the reader. In combining or contrasting particular accounts, I created new meanings and in selecting particular chunks of text I created another step between the accounts of individual participants and the reader. Thus, the processes of transcription, analysis and writing inevitably tend to carry the reader further from the meaning that the original speaker intended. However, the conveyance of meaning is always an active process that is mediated by those involved. The reader will also find her own meanings in both the chunks of text presented and this thesis as a whole. In presenting a textual version of participants' accounts I do not claim to offer either their own unadulterated version of leaving nursing, or the only possible 'nurses' perspective'. In reading this thesis, the reader engages in an active process of constructing meaning. The accounts of participants, and my analysis and

presentation of them, provide one possible way of interpreting what it means to be a nurse and to leave nursing. The 'truth' in this analysis may be judged by the extent to which nurses themselves recognise participants' accounts in their own working lives and find my analysis plausible (Melia, 1997).

In developing the analysis I have looked for dissent as well as agreement among participants. In this way I bring the weaker voices into the arena where they challenge the more dominant representations of nursing. In the interviews I encouraged participants to explore their own ideas, incorporating these into my own analysis and feeding them back to other participants in subsequent interviews. I had intended to hold feedback sessions after writing the first draft in order to give participants the opportunity to challenge my analysis or add to it, but this proved to be impossible as personal circumstances meant that I was living overseas by this stage. In writing the final thesis I have included substantial passages from the interviews, presenting participants' views and experiences in their own words and attempting to convey a sense of the people involved rather than reducing their contributions to anonymous, acontextual clips. However, as the sole author my voice inevitably dominates in my choice of passages and in the way I have contextualised them within the thesis (Riessman, 1993). Although some researchers have attempted to overcome this dominance by co-authoring papers with participants (e.g. Ellis and Berger, 2002), to some extent, the dominance of the researcher has to be accepted as inevitable and tempered by an openness and reflexivity that I hope I have achieved.

Given the sensitive nature of the subject, confidentiality was an important consideration that was raised by several participants who were concerned that they should not be identifiable. I was very careful to make clear at the outset that the interviews were confidential, that the tapes and transcripts would be locked away and that they would not carry labels identifying the participants involved. The fact that I was conducting the study in a city where I have worked for many years, and that some of the participants knew my postgraduate colleagues, made confidentiality an even more important consideration. I therefore had to take care when discussing my work and writing the thesis to protect the identity of participants.

Every participant has been given a pseudonym and I have avoided naming the specialities within which they work, as this would make them clearly identifiable to some readers. I have changed place names within the city but have not attempted to mask the identity of the city from which participants were recruited. My location in the University of Edinburgh, the small number of Scottish cities, and the unmistakable characteristics of Edinburgh itself make the location of the study clear. To pretend anonymity at this level would be disingenuous. A researcher has the responsibility to protect participants in so far as it is possible to do so but, as Punch argues, it is not possible to completely mask the identity of participants, institutions or locations from those who know them (Punch, 1994).

## **THE STRUCTURE OF THE THESIS**

The structure of this thesis inevitably reflects the critical hermeneutical approach that I have taken to the research. Consequently it does not follow the conventional format in which the 'findings' of the study are presented separately from an exhaustive literature review. In keeping with the hermeneutic nature of the analysis, in which the literature also comprises part of the data, the findings of this study are interwoven with the literature. In this way, I make the connections between individuals and their context where these interactions are relevant rather than treating the two as discrete entities.

In the first two chapters of this thesis I have set out the context within which the study was initiated and conducted, the contribution that it makes to our existing understanding of the nursing workforce, and the factors that have shaped both the research process and product. In the following chapters I present my analysis of the meaning that leaving has for nurses within the current context of NHS nursing. Each explores different aspects of nurses' experiences of and responses to dissatisfaction, but they are connected by the common thread of the difficulties that nurses face in negotiating unclear or contested boundaries from positions of relative powerlessness.

## Chapter Three

### Negotiating the Boundaries of Nursing

In 1991, a paper was published in the *Health Service Journal* entitled 'Love Nursing, Hate the Job' (Williams et al, 1991). This title effectively describes the powerful emotions demonstrated by participants in this study. Although many express an enthusiasm for, and commitment to, nursing that some describe as a passion, this is often combined with intense feelings of frustration, anger and fear surrounding the day-to-day experience of being a nurse. Running through these interviews is a sense of dislocation from the prevailing NHS management ethos, which emphasises efficiency, value-for-money and competency in tasks, and from the professional bodies that claim to represent nurses' voice in the wider world. Participants express serious concerns, and considerable frustration, that they are increasingly unable to live up to their own ideals as nurses. This frustration is by no means a new phenomenon, having been connected with nurses' desire to leave by a counsellor in Guy's Hospital, London in 1979 (Annandale Steiner, 1979). These powerful and conflicting emotions provide a useful starting point for this thesis since they serve as pointers to some of the most important issues facing nurses in the NHS.

In this chapter I begin by exploring participants' understandings of what it means to be a nurse. I ask: what is the role of a nurse, and what conditions are necessary in order that nurses can fulfil this role? Participants provide a remarkably consistent description that forms the basis for understanding their feelings of frustration, anger and fear and the desire among some to leave nursing. One of the key factors that lies behind these negative feelings is the lack of clear boundaries regarding the nature and extent of their responsibilities. Their accounts describe a life of constant uncertainty and the need to negotiate and renegotiate boundaries, often in circumstances where none of the possible outcomes is satisfactory. I begin this chapter by demonstrating the lack of clear boundaries to the role of the nurse, I show how this phenomenon relates to a widespread frustration at being unable to 'do the job' that has also been identified in several other studies (e.g. Price



Waterhouse,1988; Mackay, 1989; Meadows et al, 2000). I then identify three areas in which nurses struggle to negotiate boundaries in order to function effectively within this uncertain context. These are:

- the boundaries of responsibility;
- the boundaries between conflicting models of healthcare organisation;
- the boundaries of authority.

## **THE NURSE – A ROLE WITHOUT BOUNDARIES**

### **PARTICIPANTS' UNDERSTANDING OF THE ROLE OF THE NURSE: HOLISTIC, PATIENT CENTRED CARE.**

One of the most striking aspects of participants' accounts is the widespread agreement regarding what is at the heart of the nursing role. Each interview concluded with a request for an account of a particular episode of care that sums up nursing for the participant. From those involved in the most complex of technical care, through to nurses involved in rehabilitation and community development, there was an unanimous response that nursing is in essence about 'being with' and 'giving time' to the patient, and that nurses should base their work in an holistic approach. That is, participants stress the importance of treating patients as individuals with a wide range of emotional, social and spiritual as well as physical needs. For example, Lindsay describes a woman she cared for during her time as a ward nurse:

[There was] this woman in my general training, called Betty, and she had been wrongly diagnosed ... she hadn't been diagnosed as having a thyroid problem, and she lay in her bed the whole time. She was a big, fat lady, could hardly speak, but she had apparently been a very proud lady, always wore make-up, her appearance was beautifully done. And she was left and she had no care, *real heartfelt* care given to her. And her family were upset and I spent time putting make-up on her, making her feel better, giving her time, letting her try to communicate, sorting her hair and, OK it's not high powered nursing, but that meant a hell of a lot to that woman and her family. And that's probably what I think [of] as nursing. (Lindsay: 896-905)

Elizabeth also refers to the importance of spending time with patients and treating them as people:

I can think of some times my patients have turned to me and just said 'Thank you for being here' and for listening and just being there.

And that is *so* special. I mean I think back to when I was doing care of the elderly; particularly then there were quite a few ladies I got *very* attached to and we had very *strong* relationships, and just giving them their dignity and respect when others weren't, and that sort of thing, and them just saying thank you for that, were very special times for me and made me feel I was doing the right thing in just being there and giving them time to talk or whatever (Elizabeth: 715-725)

For both of these nurses, it is the attention to detail, and the time spent supporting and getting to know their patients as people, that provides them with a deep sense of satisfaction. In each case their actions have affirmed the humanity and dignity of the patient, and both parties have benefited from the experience. In many instances, particularly when patients are unconscious, this 'being with' role extends to family members, who are also seen as important recipients of care. For example, Jane describes the satisfaction she found in nursing one particular patient and his family after a serious accident left him unconscious:

He wasn't a well man, I spent four days looking after him, and his girlfriend and him had just moved up from England, hadn't been together that long, they were quite young. So she was on her own. So I spent a lot of time supporting her and then eventually her family came up so I spent an awful lot of time with the family ...

... I just looked after him for the four days and he did get a lot better and he ended up he was talking to me and sitting up, he even ... he was eating his lunch, and it was a sense of satisfaction. He *had* got better and that I'd had a big input into that. I'd supported the family and they were so grateful for everything I'd done. So I enjoyed that sense of achievement. (Jane: 1066-1070, 1076-1080)

The emphasis on the importance of spending time with, and getting to know, patients and their families reflects a widespread belief in the importance of treating each patient as a person and not as a collection of discrete problems. Gemma describes an example of patient care that she considers to demonstrate particularly good nursing practice:

I sorted lots of things out for this woman this day, one she had just found out that she had the wrong diagnosis. Instead of being a benign tumour it was a malignant tumour so radiotherapy and all that was an issue now. [She was] crying on the bed, worried about her children, constipated to the hilt. So that day what we did was we sorted everything out for her. Made her feel better, give her suppositories, did everything for her. Silly, silly trivial things that anybody in the street could have done, but it was just looking at *her* and realising that her whole emotional state wasn't just due to the diagnosis, it was due to lots of other wee things that made these

things worse. So it was sorting out these wee things, making her feel better, washing her hair, which was a big slut, and you know, silly, silly things. (Gemma: 1372-1383)

Gemma's account of good nursing resonates strongly with those of Lindsay, Elizabeth and Jane in her emphasis on the importance of attention to detail. However, in all four accounts these nurses diminish the importance of their actions in the language they use. For example, Elizabeth speaks of '*just* giving them their dignity' and Jane says 'I *just* looked after him for the four days' as if this was of little significance. Gemma also downgrades her work, describing her actions as 'silly, silly things', and Lindsay contrasts her work unfavourably with 'high powered nursing'. Since these nurses clearly believe that treating patients with dignity and attending to detail are important aspects of nursing, the contradiction contained in their accounts may indicate an awareness that others do not see this type of work in the same positive light. As this thesis progresses it will become clear that many nurses do struggle against perceptions that the 'basic nursing' they describe is of low value and importance. This perception contributes to the widespread lack of self-esteem among nurses that is noted by many authors (e.g. Jolley and Brykczynska, 1993; Davies, 1995; Borthwick and Galbally, 2001).

In their expectations, if not in their actual practice, participants in this study understand their role as being the provision of holistic care that incorporates the emotional as well as the physical needs of patients. As such, it is about actions as well as words and presence. In seeking to provide holistic care, many participants indicate that their aim is to meet all of the patient's needs. As student nurses, my classmates and I would write out the twelve 'Activities of Daily Living' (ADLs) described by Roper, Logan and Tierney (1980) on tongue depressors that we kept in our top pockets. We used these as *aides memoires* during the writing of care plans so that we would not miss any aspect of the patient's life in our assessment and planning. A similar concern to address every aspect of the patient's life appears in participants' accounts of nursing. For example, when asked what she expected of herself when she was practising, Elizabeth replies:

I don't know, just that people were communicated effectively with, that they knew what was happening to them, just being pleasant, *compassionate* with *people*, that they felt *cared* for and well looked after, that every one ... that their needs were met in every sense, spiritual, emotional and physical, just that that was done, that you

gave your best to ensure that people were cared for properly who were in your care. (Elizabeth: 173-179)

Lesley also indicates the wide scope of holistic nursing in her description of the response of a patient when she told him that she was leaving nursing.

and he said to me 'This is just terrible. I feel like a light has gone out in my life to know that you just sort everything out Lesley, from my bowels to my...' he said 'it's just everything. You *know what to do*. (Lesley: 513-516)

Gemma also demonstrates her perception of the all-encompassing scope of her role as a nurse in her evaluation of the care she provided for the patient described earlier.

and it's the fact that every need she's had now, since she's been involved with me, was met. Every need. Not just one need, the whole lot. (Gemma: 1389-1391)

This interpretation of holistic care creates a situation in which the responsibilities of the nurse are almost without bounds, a consequence that leads some nurses to question its usefulness as I describe later. When the central task of nursing is to ensure that the patient's every need is met, almost any task could be described as part of the nurse's role and, as Davies argues, rigid job demarcations are not possible (Davies, 1995). The problems that this 'holistic' approach creates for nurses can be seen in the vast scope of activities in which they engage, from 'washing down rooms' (Valerie: 590-595), or 'wiping bums' (Margaret: 641), to performing invasive procedures such as lumbar punctures (Lesley: 322-325), interpreting cardiac monitors (Frances: 411-422) or supporting bereaved relatives (Eileen: 989-992). As James argues, this lack of boundaries reflects the connection between nursing and the work carried out by women in the home since for nurses:

one of the effects of embracing an ideology of 'total care' is that, as in domestic care your job is never complete. (James, 1992: 498).

Although participants are generally agreed on their understanding of the nurse's role, the description given above is so broad that it does not appear to offer any means of distinguishing nursing from a variety of other roles that focus on holistic care, or spending time with vulnerable people. Neither does it appear to explain how people working in a wide range of posts are all employed as nurses. Three of the participants in this study provide examples of this diversity: Robert's work as a health visitor is close to that of a community development worker or social worker; Lesley was a specialist nurse who has, in the past, been asked to provide cover in

the absence of a senior house officer (SHO) (Lesley: 321-330); and Lindsay, who is now a school nurse, previously worked in theatre nursing where, as a 'scrub nurse', she assisted the surgeon, anticipating his needs to ensure that the operation flowed smoothly (Lindsay: 342-350). All three of these participants consider themselves to be nurses, seeing some connection between their early days as students on the wards, and their later specialities. This suggests that, in their eyes at least, there must be some common element to their work. The question remains: what is the role of the nurse? As Karen notes, this is a question that has preoccupied nurses for decades (Karen: 963-965).

Davies claims that outsiders often see nurses as 'muddled' and unable to define their own boundaries (Davies, 1995: 126). She attributes this perception to the gendered nature of the role, arguing that that nurses' work cannot be conceptualised without changing the masculine framework within which nurses work. Within this framework people slot into posts that are defined according to their expertise. However, this framework denies the role of those who provide vital supportive and connecting functions for the 'experts'. Davies claims that women in a whole range of occupations fulfil a similar function to that of wives supporting their husbands and ensuring the smooth running of the household. She cites Saks (1990), who compares nursing with clerical work, showing that, in their work of 'co-ordinating, administering, screening and nurturing', women fill a 'bureaucratic void' co-ordinating a series of people in specialist roles who are responsible only for their own sphere. In this role, secretaries, administrative and clerical workers, nurses and other women working in the service industries all carry out work that is under-conceptualized, devalued and ignored (ibid.). The connection between these roles and that of wife is also made by Summers who argues that the role of the matron in the late nineteenth century and the first half of the twentieth century was equivalent to that of the middle class housewife, presiding over all aspects of the running of her home/hospital (Summers, 1988).<sup>24</sup> Davies claims that allegations of nurses' inability to define their work arise because their words fall outside of the masculine framework and so are neither heard nor understood (Davies, 1995).

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<sup>24</sup> James adds a cautionary note to the use of this analogy, pointing out that many functions that women perform in the home are carried out by male doctors, administrators and managers in the hospital setting (James, 1992)

Although initially participants' accounts seem too vague to be useful, in the light of Davies' analysis, they do actually provide evidence of what it is that distinguishes nursing from other groups working in a healthcare setting. In the following section I show how, in seeking to define their role, nurses conform to the dominant masculine view of work and focus narrowly on expertise, a strategy that prevents them from either articulating their role to others or setting limits to their workload. I then analyse participants' accounts of their working role, based on the function that they perform within the healthcare system, in order to show why they place such emphasis on spending time with patients and treating them as individuals.

### **SEEKING TO DEFINE NURSES' AREA OF EXPERTISE**

The confusion created by a focus on expertise can be seen in the RCN document *Defining Nursing* (RCN, 2003d). The authors acknowledge a claim made by the UKCC that a definition of nursing 'would be too restrictive for the profession' (UKCC, 1999) but argue that, for the purposes of policy development, it is necessary to try (RCN, 2003d). They present their definition within the framework of the discourse of nursing as a profession, claiming that the identification of a unique body of nursing knowledge is essential since it is 'seen as one of the most defining characteristics of a profession' (ibid.: 12). The alternative, as they present it, is an inability to distinguish trained nurses from support workers and informal carers (ibid.), and other possible ways of viewing nursing are simply not recognised. The definition that they develop from this position is a complex model, the components of which they acknowledge could also apply to other healthcare professions. The authors claim that the uniqueness of nursing lies in the totality of the model (ibid.) but they do not provide a clear description of each of the components or of the body of knowledge that is 'unique to nursing' (ibid.). The result is an unwieldy and confusing definition that adds to the impression that nurses are muddled and unable to define their work.

Further barriers to defining nursing are created by the tendency of nursing theorists to focus on the narrow nurse/patient dyad. In so doing they have not addressed the question of nurses' wider role as part of a multi-disciplinary team, or the enormous overlap between activities that nurses and other healthcare professionals engage in. For example, the Roper, Logan and Tierney model of nursing provides

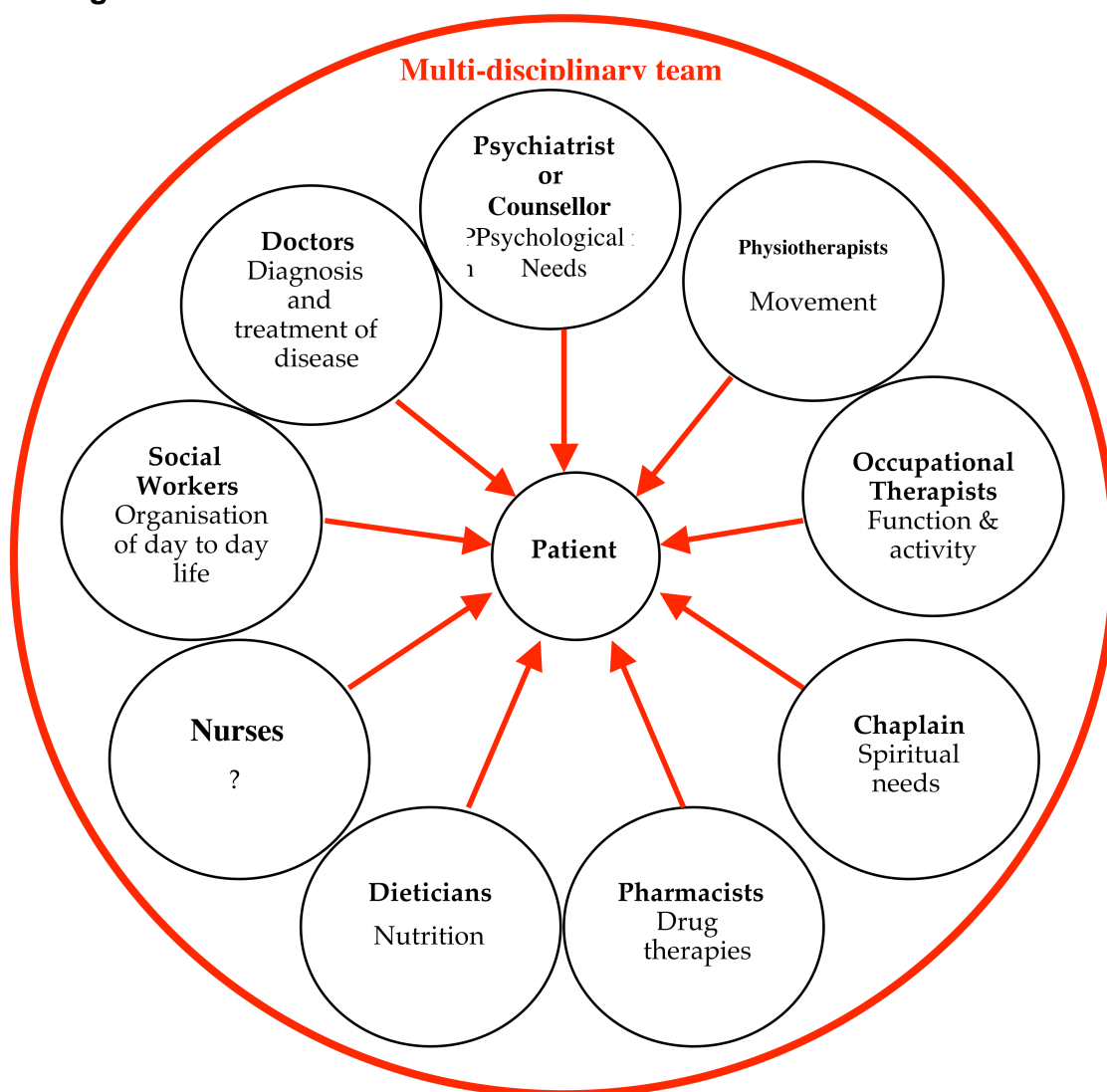
guidelines for identifying a patient's needs which cover all aspects of daily living, but it does not make clear which occupational group has the responsibility for meeting each identified need (Roper, Logan and Tierney, 1980). Orem's model emphasises the goal of bringing the patient to her maximum potential in terms of independence, but this could be seen as the goal of other health professions too (Orem, 1985). Neuman's model, based on systems theory, looks at the patient within the context of her system but does not explore the place of the nurse within her system (Neuman, 1995). A similar issue arises in the field of nursing research where researchers have sought to develop a body of knowledge for nursing as the basis for its mantra of 'evidence based practice'. However, they have not clarified what function that knowledge should relate to and consequently there are major overlaps between nursing research and that carried out in other fields.

This focus on expertise as the basis for nurses' role can create confusion for practising nurses as well as academics as is apparent in Elizabeth's response to the question: what sort of a role do you see nurses as having within the healthcare team?

well I think they have a very important role. They ... I am (...) ... you know, I *see* them as independent practitioners in the sense of (...) well, ultimate ... yes (...) they *are* practitioners in their own right and I feel very strongly about that and, em, and they give ... they give the practical, hands on care. I know it is prescribed by doctors but nurses have a lot of autonomy and responsibility *in* that. (Elizabeth: 277-282 )

The problems created by seeking to describe nurses as one of a number of groups of experts contributing to a patients' care are illustrated in diagram one. The large red circle represents the whole healthcare team, with the patient at the centre as the focus of activity. Each expert group contained within the team contributes something different to the patient.

**Diagram One**



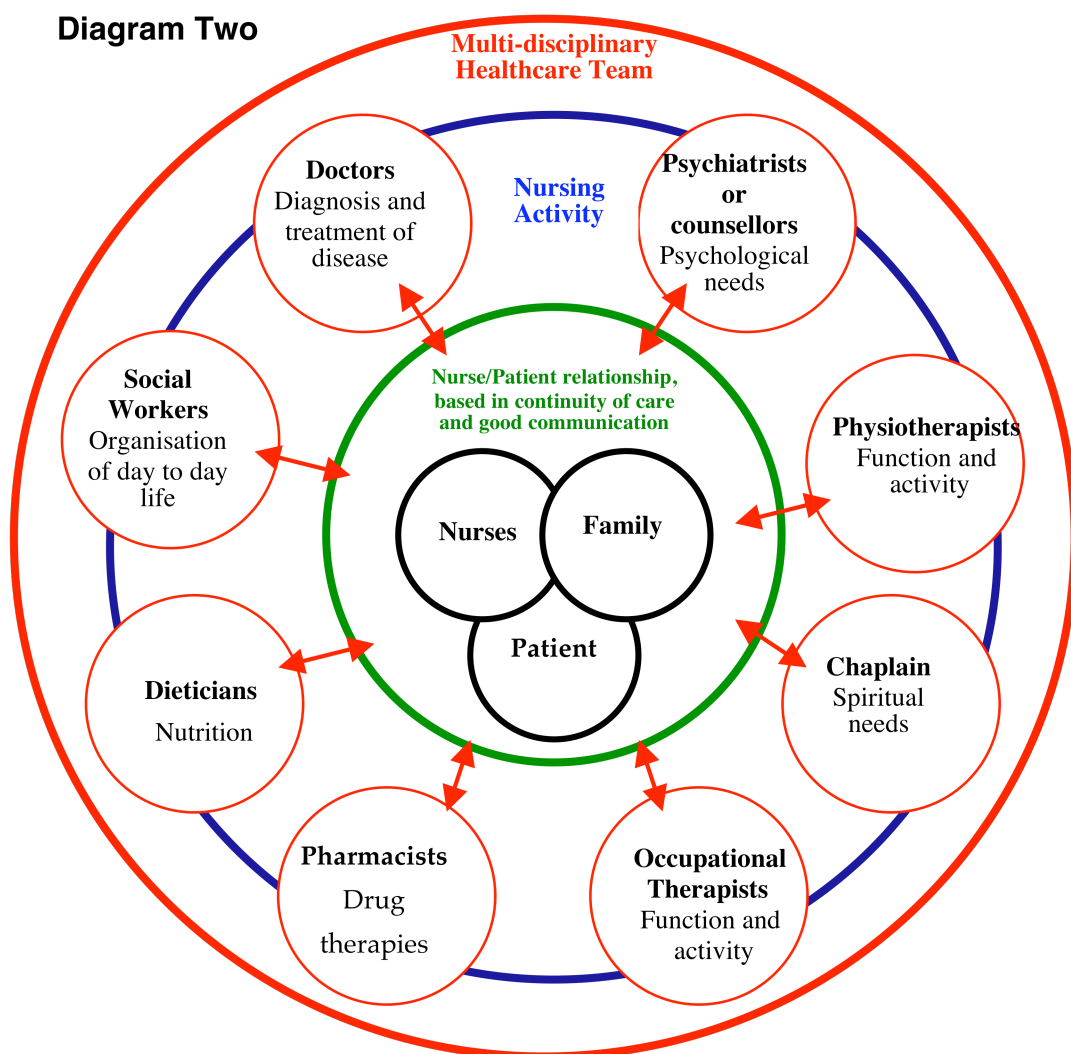
Several problems are immediately apparent from this model. First, it lacks any unifying force to draw the different contributors into any form of holistic care. Second, in defining expertise according to a breakdown of patients into discrete areas of need there is no one aspect of patient's psychological, spiritual, social or physical needs which is not already covered by another group. Where does this leave nurses as experts? Third, this model does not show how nurses draw from each of the other fields in their day-to-day practice. Fourthly, it leaves the patient isolated and fragmented in the centre, the object of other people's expertise with no part to play in her own care. This is indeed the experience that some patients have of hospitalisation as Elizabeth's account of her own admission, cited on page 130 shows.



## **UNDERSTANDING THE ROLE OF THE NURSE WITHIN THE HEALTHCARE SYSTEM**

In order to understand participants' interpretation of their role as nurses it is necessary to place them in context within the healthcare system. Nurses usually work in teams. Even in the community, caseload holders are likely to work with more junior staff members and to co-operate with other caseload holders in order to maintain a continuous service. In order to fulfil the functions described in the nursing models cited above, nurses must liaise and co-operate with a wide variety of other people. These include other healthcare professionals, support staff within the healthcare Trust, social services and other organisations beyond the Trust, as well as the patient and her family and friends. Diagram Two shows how nurses are part of a complex system of healthcare that surrounds and includes patients and their families, and describes the role that nurses play within that system.

**Diagram Two**



The large red circle in this model represents the multi-disciplinary healthcare team. The blue circle represents the sum of nursing's contribution to patient care as a part of that team. The black circles, representing other groups within the multi-disciplinary team, overlap this circle of nursing, indicating that, while these groups are specialists in their own fields, and can act independently of nurses, nurses share some of their knowledge. In order to achieve holistic care, nurses will use this knowledge independently as the basis for their own decisions, they will call on the 'experts' when they deem it necessary, and they will carry out the instructions of these 'experts' in their absence. At the heart of the system is a circle representing the relationship between the nurses, the patient and her family. The use of nurses

in the plural points both to the fact that one patient may develop a relationship with more than one nurse, and that the nurses operate as a team, pooling their knowledge of individual patients and providing a continuous presence in a relay of shifts. While other members of the multi-disciplinary team can, and do, develop relationships with patients, the particular nurse/patient relationship is different in the frequency and degree of contact, and in its relevance for the functioning of the whole system.

Within this context, participants describe a role that, in addition to the hands on care of patients has three interconnecting functions. These are:

- gathering information about the patient as a person;
- co-ordinating the input of all those involved in their care;
- protecting the humanity of the patient within a potentially dehumanising system.

All of these functions rely upon nurses' knowledge of both patients as individuals and of the healthcare system in which they work.

### **The Nurses' Role in Getting to Know the Patient as a Person**

The context specific information, which flows from the nurse/patient relationship, is necessary in order for all members of the team to tailor their input to the needs of that individual. A doctor's understanding of the factors influencing the development of a medical condition may be profoundly influenced by knowledge of the patient's lifestyle and activities leading up to their illness. Some of this information can be gathered in the initial doctor-patient interview, but often highly relevant information only comes to light later, simply because the doctor didn't ask the necessary question, and the patient didn't realise the significance of that information. Such information may be confided in the nurse when greater trust has been developed, or it may come to light almost accidentally through their day-to-day interactions. Information is gathered through observation as well as conversation. As Karen notes, observation is a key nursing skill, which is facilitated by prolonged contact (Karen: 958-962). This observation relies upon the nurse's knowledge of a wide range of specialist fields since she needs to know what is and is not clinically significant. At the same time, her context specific knowledge of

what is normal for the patient allows her to pick up on changes and abnormalities that more distant members of the team would not recognise. As a nurse myself, on several occasions I have been able to alert medical staff to an imminent crisis on the basis of such observations when a health worker who did not know the patient would have seen nothing.

### **The Nurse's Role as Humaniser**

When a nurse and patient are able to develop a relationship based in trust, the nurse can act as the human face of the organisation and make the patient's, and her family's, experience of healthcare less impersonal and frightening. The nurse's understanding of the organisation and how it functions, together with her medical, social and psychological knowledge, allow her to act as support, teacher and guide to people who are often on unfamiliar territory and going through strange and disturbing experiences. The effect of this role can be seen in the difference between the two diagrams above. In diagram one the patient is alone and isolated, while in diagram two she is accompanied by familiar and knowledgeable nurses and so has access to support and information that can potentially reduce that sense of isolation. Barbara's description of an incident in which she met the family of a patient for the first time, illustrates the role which nurses play as information resources and guides, offering support in a complex system:

I sat and I listened and we took every individual problem that they perceived and we discussed it and I suggested what I could do and then at the end it was like 'Now, this is what I'm going to do when I go away, der, der, der, der, der. Is that OK?' and that was *fine* 'and is there anything else while I'm *here*?' and we discussed anything else and then it was a case of 'well this is my phone number and I'll be back on such and such a *day*. However, if in the meantime you remember anything *else* or you're *worried* this is the number you *ring* and I will come back straight *away*. This sounds very kind of big headed but it isn't, or it's not intended to be certainly, I *knew* when I left that all these fears, when I'd met these three *very* anxious people were allayed and that has to give you a buzz (laughs). But I could only do it because of all my experience and *knowing* how the system works, which obviously, as a patient you don't (Barbara: 981-995)

This particular incident took place in a community setting, but nurses perform the same role in the hospital setting, as Maria indicates:

I'm there to help people, and even if the outcome isn't great, you feel well what I've got out of that is to let somebody die with dignity, and in the way that they wanted everything to happen with the support for the family, and make sure that everybody's coping with it as best they can and giving them the support and the information that they need (Maria: 671-676)

The importance of this role is illustrated by Elizabeth who draws on her own experiences as a patient to think about how patients feel without this kind of guidance and support.

There's such a *lack* of communication with people. They don't feel cared for. It's a very *lonely* time for them, a frightening time and I know from my own experience of being in hospital, the communication was *appalling*. I was a nurse and I *knew* what to expect but people didn't *discuss* things with me or *involve* me. Nobody ever said anything to me, it was just *awful*, I mean people hardly came to see me. It was just appalling, and as a layperson that must be *very* frightening not to know what's happening to you and what's going on. And just being *informed* of progress or whatever, you know, it just doesn't happen. And I feel that's appalling. It is *not* good nursing. (Elizabeth:179-190)

This extract also points to the dissonance between Elizabeth's ideals and her experiences both as a nurse and as a patient, a phenomenon that I explore in greater detail below. In some instances, the nurse's role as humaniser is much more extreme in that she restores the humanity of patients who have been dehumanised by a system that focuses on efficiency and productivity. These experiences provide powerful rewards for the nurses concerned as I show in chapter six.

### **Nurses' Role in Co-ordinating Patient's Care**

In addition to nurses' role as the mediators of information between the patient and the team, and as the human face of the organisation, their constant presence supports a vital organisational role. When asked 'What is it that you think nurses do within multi-disciplinary teams that other people are not doing?', Eileen describes this organisational, connective aspect of her work:

- |        |   |
|--------|---|
| Eileen | Well, you can often find you're the one who liaises with all the different departments, especially in the community. If someone's got a package of care you can often be the person who will go in and then contact everybody else if there's a problem with that [the delivery of the care package]. |
| Alison | So you're sort of connecting all the different parts ...  |

Eileen            Yes.  
Alison           ... together?  
Eileen           Yeah. (Eileen: 884-891)

Liz describes the same role:

[The nurse's role is] to communicate very closely with medical staff, to work closely with them, to be involved with decision making, to communicate with the domestics, to just *care* totally for the person but then to communicate with other people involved in the care of the patient. (Liz: 722-725)

In the hospital setting, this role as the central liaison point is facilitated by the twenty-four-hour presence of the nursing team. This means that they are accessible to other members of the multi-disciplinary team, to the patient and to the family at any time. Their knowledge of the system, combined with specific knowledge of the patient, makes it possible for them to 'see the big picture' (David: 65-66). They are, therefore, the ideal people to oversee the organisation of patient care, ensuring that everything runs smoothly, and everyone concerned is made aware of both the current situation and the plans for the future. In acting as conduits of information which link all the parts of the team, and in providing stability through their twenty-four-hour presence, nurses act as an organising principle or connecting matrix, creating a co-ordinated whole from a mass of discrete parts. Different people within the healthcare setting can and do communicate with each other, and this is vital, but without the stable presence of a nursing team, the care offered to patients and their families becomes disjointed and haphazard.

Although nurses' access to, and knowledge of, individual patients allows them to play a pivotal role in the healthcare team, the importance of this role is often not noticed. When asked how she views the role of the nurse, Karen illustrates the confusion nurses face when trying to base their definition in the tasks they perform rather than their broader contribution to the team.

Nurses are obviously the people in the healthcare team that have got the twenty-four-hour responsibility for the care, so they're just a bit of everything aren't they? I mean, we've got the ability to be with the patients *twenty four* hours a day, to *observe* them twenty four hours a day, to *support* them twenty four hours a day, to *assess* them twenty four hours a day and to feed back and to meet with the relatives a lot more than anybody else, to discuss their whole situation more than anybody else. But actually *defining* the nurses' *role* is just so ... I mean it's been tried to be done for such a long time and it's just *absolutely* impossible because it's just a bit of everything.

We do physiotherapy with our patients, and we do that a lot on the ward because obviously we work so closely with the physios. And we get the patients up and dressed every single day so obviously we do a bit of OT<sup>25</sup> and then there's a *huge* amount of social work involved in our role so to actually pin point where we're at is very difficult. (Karen: 956-970)

Without realising it, Karen gives a beautiful description of the difference between her role and that of non-nursing colleagues, but fails to recognise the significance of that difference, focusing instead on the 'jack-of-all-trades' aspect of her work. This is a phrase that Margaret uses to describe nurses' role within the healthcare team (Margaret: 398-407), and which downplays the nurse's importance, contributing to an invisibility and lack of self-confidence among nurses that I explore further in chapter five.

### **WHEN IS A TASK A NURSING TASK?**

For most members of the multi-disciplinary healthcare team, clear boundaries, based on expertise, allow them to define relatively clearly what is and is not within their remit. For example, a doctor can be identified through her involvement in diagnosis and treatment and is not expected to make beds. A physiotherapist is concerned with patient's mobility and is not expected to administer drugs. A counsellor offers counselling and does not teach a patient how to dress herself. Nurses are different in that they are involved in, or carry out, all of these functions but their role is not defined through their activities. If specific activities were the basis for the role, a nurse would be a doctor and a cleaner, a tea lady, a chaplain, counsellor, dietician, teacher and personal maid all at once. In the following section I show how nurses' rationale for defining appropriate activities differs from that of others involved in patient care.

The overlap between nurses' role and that of other healthcare professionals can create a situation in which nurses struggle to contain the boundaries of their workload and have to set their own limits on what is and is not an appropriate activity. As a specialist nurse, Christine describes the tension between maintaining her role as a nurse and her perception that sometimes it is important to carry out medical procedures:

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<sup>25</sup> Occupational Therapy

I'm trying in the middle to keep my job very much nursing orientated and not being pulled towards being almost like a junior medic or doing phlebotomy all day, and taking up the tasks that the junior doctor's hours are trying to reduce. I know things that they don't want to do anymore, but then I think that in some ways nursing is going backwards with some of the new policies and things that are coming out like reducing the amount of IVs<sup>26</sup> that nurses can do, and restricting tasks that were just things that actually facilitated patient care and facilitated holistic views of a patient. (Christine: 667-675)

The principle underpinning Christine's role boundary is that of holistic nursing; the patient should receive care when she, as an individual, needs it and not just when the doctor is able to fit her into a busy schedule. When a doctor is not available, Christine is happy to carry out 'medical tasks' in the interests of holistic care. However, she is not prepared to take responsibility for performing these tasks regularly in order that the Trust can meet its obligations regarding the reduction in junior doctors' hours.

Similar boundary issues are raised in relation to documentation. For example, although documentation is seen as an essential part of nursing communication, participants draw the line when the purpose of that documentation is no longer seen as serving the interests of the patients, or when it takes up time which is needed for patient contact. Nurses are frequently described as hands on clinical practitioners and not desk workers or managers and 'paper work' is a phrase that is often expressed with scorn. Several participants' stories centre on the conflict with managers regarding paperwork and for others the word is used with a barely concealed contempt. These nurses are not rejecting the need for documentation *per se*. However, it appears that 'paperwork' is used as a shorthand expression of their dislike for their managers' model of healthcare. The following extract describes a situation in which Jean came into conflict with her manager over the requirement to complete both computer and paper records of her work, which reduced the time available for direct contact with patients.

I said 'Well, what happens if I've got to choose between a patient and the computer? Are you telling me I've got to choose the computer?'. [and the manager said] 'Yes.' And I was told that. And I was told

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<sup>26</sup> IV - Intravenous therapy. Christine may have been referring either to inserting the needle through which the fluid is administered, or to the actual administration of drugs through the intravenous fluids.



that about the terminal care patients as well, and [she said] my responsibility was to the paperwork and computer first.

[the manager said] 'Yes. That's part of your contract'. Somebody else will come along in the evening shift to see the patient if you haven't done ...', [I replied] 'Well fine.' (Jean: 1185-1189, 1191-1192)

Jean's account of this interaction with her manager illustrates the fundamental conflict between nurses' understanding of their role and that of other groups within the healthcare setting. I return to this issue later in this chapter.

Unskilled, manual work raises the same issue. For example, Eileen spent some time as the store nurse in a supermarket, and describes how she was sometimes expected to carry out tasks such as filing or checking prices for customers.

I mean in a ward yes, you don't mind cleaning a locker because it's an essential thing, if you've got someone else coming in, but going to find out the price of a tin of beans isn't relevant to your nursing role or the care of anybody, apart from the fact the customer might get out a wee bit quicker because they've got their tin of beans (Eileen: 869-873)

The same principle seems to apply here as in the previous examples. Eileen sees cleaning a locker as part of the overall aim of making a patient comfortable. However, the menial tasks that she was required to do as a store nurse bore no relation to any form of care and were seen as demeaning to her status as a trained nurse. The conflict with her manager over this point, and what she saw as her position as a 'token' nurse in the store later led her to leave this post.

### **FULFILLING THE ROLE OF THE NURSE: THE IMPORTANCE OF STABILITY**

In order to clarify why participants express such frustration at their inability to 'do the job', I now explore the conditions that they require in order to fulfil the role described above. The main condition is that of continuity of contact both between a patient and her nurses, and among the members of a nursing team. This facilitates both the development of the nurse/patient relationship and the ability of the team to function as a unit rather than as a series of individuals.

In her description of the nurse's role cited above, Karen refers to the constant presence of nursing staff in the hospital setting. Margaret identifies the importance of this presence in terms of the opportunity it provides for nurses to get to know their patients as individuals.

I mean we're there 24/7 and I think that's a really important part. You get some doctors who come in and think they know the patient and they've only just seen them. (Margaret: 403-406)

If taken literally, one could read this claim as meaning that individual nurses are present around the clock. However, this is clearly nonsense. The presence that Margaret and Karen refer to is that of the team, but the way in which this twenty-four-hour presence is described conveys a sense that the nursing team is a single entity. This apparently pedantic observation points to the important fact that individual nurses cannot perform the role described above, simply because they are unable to be present twenty-four hours a day. The organisational aspect of the role depends upon effective communication between team members so that they can operate in a seamless fashion from shift to shift. Highly individual relationships between nurses and patients take place within the context of a team of nurses who pool their knowledge in order to provide that twenty-four-hour presence. A group of individuals is not the same as a functioning team, and effective teamwork depends upon the relationship between team members as well as upon effective communication. Participants describe disturbances in both of these factors, which influenced the ability of their teams to function effectively as a whole. These often relate to the use of agency or bank staff although high levels of turnover are also a contributing factor.

The importance of a personal knowledge of patients, based on prolonged and close contact, also appears in the community context, despite the comparative brevity of nurses' visits, and the lack of a twenty-four-hour presence. Indeed, several district nurses participating in the study moved to community nursing precisely because it provides greater opportunities for developing relationships with patients (Jean 30-41; Judy: 188-194; Anne: 83-93; Eileen: 914-927). Their experience of hospital nursing was of an environment in which there was often neither the time nor the continuity of nursing staff to develop the nurse/patient relationship. From their accounts, what community nursing lacks in terms of intense, short term contact, it seems to make up for in prolonged periods of visiting, often extending over many years. As Eileen explains:

you get more involved with the patients, you get to know them. They're not just someone in a bed that you're gonnae see for a couple of days if you're lucky and then they're chucked out. These are often people that we're going in to for long periods so you get to know

them. You get to know their family. There's a different kind of contact with them than there is in a hospital situation. You do have more time for people usually and I like that. (Eileen: 919-927)

The ideal situation, in which nurses are able to spend time getting to know their patients as people, allows for a whole range of other functions. Nurses are not simply 'being with' their patients, sitting and talking or listening; they also foster the relationship and develop an understanding of the patient as an individual through periods of activity. In complaining about students' narrow view of performing a simple task, Christine describes the part of her nursing role that goes unseen when she gives a patient a bed bath:

Certainly we've had a lot of students that after the fourth or fifth bed bath or assisted wash are giving it 'Don't see the learning opportunities in that' [but they're not thinking about] skin care, eye care, you can get a whole patient's social history by doing a bed bath. There's more to doing a bed bath than washing a patient, and you actually glean much more information. (Christine: 459-465)

In her reflections on the attitudes of student nurses, Christine points to the aspects of nursing care that are invisible to a casual observer. A skilled nurse does not simply wash a patient, she performs a complete, holistic assessment of the person she is bathing. For example, with a person who has suffered a stroke, a nurse will assess the state of the patient's skin, her mobility, her progress towards being self-caring, her ability to speak clearly and understand others, and her mood. The nurse may also use the time for rehabilitation, teaching her how to wash and dress herself again.

Liz also uses Christine's example of a bath to demonstrate the importance of holistic care (Liz: 705-712) and in conversations with many other nurses, and in texts written by nurses, I have often encountered the example of bathing a patient given to demonstrate the vital role of 'basic care' (e.g. Clarke, 1999; Fleming, 2002). It seems that for nurses concerned at the move away from basic care, bathing has a particular significance. This may be due to the fact that it is one of the few occasions when a nurse and patient spend time together in privacy. As well as offering an ideal opportunity for assessment, the way in which a nurse bathes a patient has enormous significance for the relationship between them. The suggestion that anyone can give a bath indicates that the person is simply a body to be washed. Such an experience could be extremely degrading and humiliating.

This potential is illustrated in the following remark made by a student nurse who participated in Melia's study of students' socialisation into nursing.

you could have a sister who says you must be done by 10am, and  
you still have two legs and a bottom to do. (Melia, 1987: 15)

For me, this quotation conjures up an image of an anxious student nurse, sitting by a pile of unwashed body parts, in much the same way as a soldier might sit next to a pile of potatoes that he is peeling. In contrast, a nurse who treats a patient as a human being, recognising and seeking to avoid the potential humiliation of the experience, lays the foundations of trust and mutual respect that allow her to function in her role as humaniser and co-ordinator. The position taken by the nurses cited above rests on a belief that, in delegating bathing of patients to HCAs, these valuable opportunities for holistic nursing care are lost.

Continuity of contact between patients and nurses, and among members of a nursing team, is not simply a desirable situation that facilitates a supportive relationship. It is also central to the co-ordinating function of nurses. In order to provide a seamless, twenty-four-hour presence, nurses need to work as a team of individuals who know and trust each other, and who can pass on vital information from shift to shift.

#### **FULFILLING THE ROLE OF THE NURSE: THE IMPORTANCE OF HIGH STANDARDS**

Throughout the interviews I was particularly struck by the high expectations that participants had of themselves and their fellow nurses. At times the standard seemed almost inhuman and unrealistic. Such high ideals and a tendency towards perfectionism are not restricted to nursing. Henning et al (1998) report a high incidence of perfectionism among medical, nursing, dental and pharmacy students that contributes to high levels of psychological problems. Alexander attributes a high suicide rate among dentists, in part, to a tendency towards perfectionism (Alexander, 2001). The connection between perfectionism and suicide can also be seen in a news report of the suicide of a GP in Manchester who is described as a 'perfectionist who became depressed at her inability to do more for her patients (BBC, 2003d).

Although the degree of realism among participants varies, all share a common concern to maintain a high standard of care in their work. This may simply reflect

on the type of nurse who volunteered to participate in the study. It seems unlikely that all nurses share their high expectations, and certainly several participants comment on their frustration with colleagues whose standards they perceived as unacceptable. For example, Margaret comments:

I'm very conscientious and I guess I do have standards and it pisses me off when people don't have the same standards, but, I probably shouldn't expect that either. (Margaret: 189-191)

Whatever the level set by individual nurses, the language of healthcare in government, NHS and professional documents (e.g. Scottish Office, 1998; NHS Executive 1998; RCN, 2000) sets a background expectation of high standards. Eileen's account of her early experience as a student in the 1970s illustrates the expectations into which she and her classmates were socialised:

the first matron that I worked with, she took us all into her office, one at a time, when we started there as student nurses. And I always remember her saying to me 'You are here for your training, and at this hospital, we look at the whole patient, and we care for the whole patient, and we expect the greatest of care to be given to that patient, and we don't expect you to falter from that. (Eileen: 119-126)

Eileen has accepted and maintained these expectations throughout her career:

I'd be very upset if somebody came to me and said 'You don't do that very well', or, 'You don't look after someone well' because I don't believe that I do, and I think in the community, because you do work on your own, it's something that you have to keep at the back of your head. There isn't someone looking over your shoulder so it's up to you to keep your standard of care (Eileen: 117-141)

While Eileen was socialised into an expectation of high standards as a student in the 1970s, a concern with giving one's best at all times is not the preserve of older nurses. Maria, who has been qualified for four years comments:

I would hate to think that I was doing something badly, and if I wasn't I'd want somebody to say 'Hey Maria, you need to get your act together on that one', because I'd hate to ever lessen myself and my standards [and] to think that I wasn't doing things to the best of my ability. (Maria: 941-944)

For this staff nurse at least, providing the best care possible is an essential part of being a nurse.

In their descriptions of the role of the nurse, participants stress the importance of two main dimensions. First, that nurses play a vital role in ensuring that patients maintain their dignity as people within a potentially de-humanising situation; and,

second, that nurses provide the glue that binds the input of a large number of people into a cohesive service. These interconnected roles rely upon a continuity of contact between nurses and patients, and between members of the nursing team. They also demand that nurses should at all times base their work in the ethic of care, treating their patients as people. This ethic underpins an occupational discourse of extremely high standards in which the benchmark of care is what the nurse would expect for herself or her family (e.g. Christine: 801-802; Claire: 636-649). For Christine, the provision of a high standard of care is not simply a desirable goal but a matter of justice:

- Alison        You said there something about being a terrible person  
                  if you didn't do the work well.
- Christine     But that's just my own personal expectations of me.
- Alison        So being a good person is being good at work?
- Christine     Yes, and achieving, and offering the service which  
                  they've either come to expect or that I have said that I  
                  am going to offer, and if I fall short of that I feel that I  
                  am doing them an injustice. (Christine: 764-773)

In labelling a failure to meet the agreed standard of care as 'an injustice', Christine points to the moral dimension of a commitment to nursing and the way in which it provides a powerful incentive for nurses. A commitment to nursing entails a commitment to high standards, and a nurse who fails to provide a high standard of care risks not only the label 'bad nurse' but also that of 'bad person'.

The nature of nursing, as described above, and the standard of care expected, share a common lack of clear boundaries that is both a problem and an essential part of nursing. Effective nursing occurs because the team provides a continuous, twenty-four-hour-a-day, seven-day-a-week presence, and because nurses' knowledge and activity overlap with those of other members of the multi-disciplinary team. Extremely high standards, based on the premise that vulnerable people have a right to expect the best care possible, serve to protect patients and to motivate nurses. However, the uncertainty caused by a lack of clear boundaries creates a great deal of anxiety for nurses who need to establish some limits to their role and to the effort they put into achieving a high standard of care in order to function at all.

## **A ROLE WITHOUT BOUNDARIES: CONFLICT, CONFUSION AND CHALLENGE**

Thus far I have described participants' understanding of their role, their rationale for determining which activities are and are not appropriate within that role, and the importance of stability and an expectation of high standards to the fulfilling of that role. In so doing I have described an ideal rather than the reality, although already the disparity between the ideal and the reality is clear within participants' accounts. Nurses work within a complex system in which there are many different perspectives on the role of those involved and the way in which the system should be organised. This requires them to negotiate their position in order to turn their ideals into reality. Nurses' success in this task depends upon their ability to define their role, to control the resources they require, to shape the structures within which they work, and to influence the decisions that are made within their workplace, their Trust and in the NHS as a whole. Participants describe a situation in which they are constantly required to negotiate the boundaries of their role and the extent of their authority to make decisions within a constantly shifting situation. Much of the frustration expressed by participants reflects the obstacles they encounter to achieving their ideals. In some cases the frustration experienced seems to originate in the unreachable ideals that nurses hold. However, participants also describe how they struggle to achieve even a basic level of safety within a system that is organised in ways that prevent them from fulfilling their role as they understand it. Their difficulties are compounded by a profound feeling and experience of powerlessness that impedes their ability to negotiate the boundaries of their responsibility, the size of their workload or the way in which their work is organised. Participants describe a situation in which they are caught between high professional ideals with real penalties for failure, and a situation in which they are unable to fulfil their obligations. It is this frustration at an impossible situation that prompts Meadows et al to claim that nursing is a 'powder keg ready to explode' (Meadows et al, 2000: 36).

## NURSING AN UNATTAINABLE IDEAL?

According to the dominant discourse of nursing, patients are vulnerable people who deserve to be given the care that nurses would expect for themselves or their families. However, in a situation where nurses are charged with the care of large numbers of patients, such high expectations may be beyond the realms of possibility, even under ideal conditions. Indeed, among participants there is some recognition that they will never meet their expectations. For example, Jean comments, 'I'll never meet my expectations they're a bit perfectionist.' (Jean: 658-662). Christine shares her perspective, referring to a friend whose expectations are so high that she always falls short of them and is disappointed (Christine: 242-245).

While these nurses recognise that reaching an ideal is not always possible, several participants speak of their difficulty in reaching even a basic standard of care. In such cases, the disparity between nurses' ideals and their experiences create immense frustration and anger. The continuing expectation of high standards by employers, and the possibility of facing disciplinary procedures, combine with nurses' recognition that it is patients who suffer when standards drop, to create a great deal of fear. As Frances comments, 'if something goes wrong it will be *my registration*.' (580-581), a fear that is shared by another nurse whose strength of feeling prompted her to write to the *Nursing Times* (Anonymous Nurse, 2000a). Jane provides a detailed account of the kind of situation that creates this fear.

it's really difficult to try and maintain a high standard of care. Especially in high dependency, funded for four beds and yesterday we had eleven patients. That means you've got to spread the nurses out, but it should be at least one nurse to two patients, but I could quite easily look after one patient all day and be really busy, and we've got eleven patients and have to spread the nurses so thinly and it actually becomes *dangerous* after a while. So your main priority is just maintaining a safe environment for the patients, which means that other things get put to the side. Just even *talking* with your patients or spending *time* with your patients just doesn't happen because there's not enough time and there's not enough *staff*, there's not good enough facilities. You're looking after four highly dependant patients on a bay on the ward where there isn't even suction working properly. I mean this department is particularly bad I think and it's getting really run down, and they'll stick one new staff nurse in a run down old bay looking after four really ill *patients* so your main priority is just to try and work safely and maintain the safety of the patients. It's not *always* like that but when it is really busy ... (Jane: 277-298)



For Jane, providing a high standard of care is sometimes an impossible goal under circumstances that made the achievement of a basic level of safety a struggle. This struggle against the constraints of inadequate resources and heavy workloads is intensified by the increasing expectations of patients over the past decade. In 1991, the Conservative Government introduced the *Patient's Charter*, a document detailing the standard of care that patients within the NHS have a right to expect (DoH, 1991). This was combined with a high profile policy of providing each patient with a 'named nurse'. While these ideals correspond closely with those of nurses themselves, the raising of patients' expectations was not combined with policies that provided nurses with the means to meet their obligations. Jean's experiences as a district nurse distributing copies of *The Patient's Charter* illustrate the problems that this policy created for nurses.

We were getting all these patient contracts and things to hand out to patients saying 'Your rights from your named nurse.' They've quickly got withdrawn because you couldn't possibly give somebody a piece of paper with a named nurse when the named nurse *changed* every day, but patients were getting all these statements saying 'these are your rights, you're entitled to this service, that service, the other service.' 'That's if social work have got the money and if we've got the staff and all these other things. It was just ... *that's* what they were spending all their money on. And they were *right*. I mean, patients should have had these *rights* but as they didn't it was a bit ironic to have us handing them out saying 'By the way, although these are your rights, this is the reality.' It was bizarre. (Jean: 1268-1282)

Although Jean's employers withdrew the leaflets that caused her such difficulties, this did not solve her basic problem, i.e., the constant feeling that she was not providing the care to which her she believed patients were entitled. Her objection was not to the standard that was set out in the leaflets, but to a situation in which she was unable to meet that standard. The leaflet simply served to highlight the inadequacies of her patients' care and to place the responsibility for its provision on nurses who were not given the means to fulfil that responsibility.

#### THE PROBLEM OF A LACK OF CONTACT WITH PATIENTS

The difficulties I describe in chapter two, regarding finding a ward where patients spend long enough to develop relationships with their nurses, reflect a trend towards shorter in-patient stays across Britain. One manager with whom I liased in

arranging this study suggested that this trend might be a part of nurses' dissatisfaction at work, since the opportunities to get to know patients are decreasing (personal communication, 2001). Her suggestion is supported by the connection between participants' feelings of frustration at being unable to fulfil the role described above and their experiences of fractured healthcare provision. They describe situations in which it is difficult, or sometimes impossible, to spend enough time with patients to provide holistic care or to develop a sense of 'the big picture' (David: 66). In hospitals, the increased throughput of patients, combined with shortages of nursing staff, create a heavy workload for the nursing staff, which means that the use of a task oriented approach to organising the workload is sometimes the only way in which the safety of patients can be achieved. As Jane indicates, holistic care is sacrificed in the interests of safety. Jean's account of district nursing shows that a similar fragmentation of the service can occur here too:

I mean it was very much a case of 'Well they need general nursing care<sup>27</sup>. You call in an auxiliary from wherever. If there's an auxiliary passes by that street *they* can go and do that. *You* can go in and if there's a syringe driver needs re-sited you do that.' You would have four or five people going in [to one patient's home] in the course of a day to do a bit. There was *no* continuity of care. I suppose I was responsible for overseeing it but it's a bit difficult to oversee people you don't even know (Jean: 113-120)

As a district nurse, with responsibility for overseeing the work of this 'team', Jean's fear of mistakes and omissions is clear, as is her distress at what she perceives as the consequent poor standard of care. These feelings of fear and frustration were key in her decision to leave nursing.

## THE PROBLEM OF UNSTABLE NURSING TEAMS

As well as highlighting the discontinuity of patients' care, Jean's account also points to the way in which unstable nursing teams struggle to function as effective units. As she describes, nursing teams may be destabilised by the frequent use of agency or bank staff who do not know the patients, the staff, the ward or the caseload. As I show in chapter one, the financial cost incurred through this practice

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<sup>27</sup> General nursing care and basic nursing care are terms used to describe the work that nurses engage in to meet the basic physical needs of patients, e.g. bathing, feeding, dressing, toileting.

has become a headline issue in recent years. However, the costs in terms of stress to permanent members of staff, damage to team cohesion, and the loss of continuity of patient care are also important considerations that have been recognised in a report for the Royal College of Physicians (Ryan, 2000a). Maria describes the difficulty of leading a fragmented 'team' in a hospital setting:

it's 28 beds and you'd be lucky if you had one staff nurse and an auxiliary on one side<sup>28</sup> and one staff nurse and an auxiliary ... and somebody in charge. So I had a new start<sup>29</sup> on one side and a bank nurse on the other, so two people that didn't really know the ward and you're stuck, and I just felt so stressful, (Maria: 107-112)

The problems of fragmented or unstable teams are exacerbated by an associated lack of experience and confidence. For example, Christine, describes her difficulties in maintaining the necessary level of knowledge and skills among nurses in her department:

I can't talk about other units but certainly ours, its just dire. I mean people are staying three months, they're moving through the unit every three months and you're on this ever decreasing wheel to try and educate people. (Christine: 400-413)

A shortage of trained nurses, and high levels of turnover contribute to a situation in which the senior staff on a ward may be relatively young and inexperienced. This creates a great deal of anxiety for both themselves and more junior nurses who need guidance and support. Newly qualified nurses in particular find the lack of support in many workplaces extremely stressful as they pass through the transition from student to staff nurse. This period is often characterised by a sudden increase in the level of responsibility combined with a heightened awareness of their accountability (Gerrish, 2000). Gemma, who is responsible for staff development and support in her department, claims that there have been fifty four new nursing staff in her department within the past year (Gemma: 20). She links the loss of experienced staff to the difficulties which new staff nurses experience:

All of a sudden they [the newly qualified staff nurses] are accountable and they are responsible for looking after ten or eleven

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<sup>28</sup> Maria is referring to the way in which Nightingale wards have beds running down two sides of one long room. In the situation she describes, there are 14 beds on each side of the ward. In addition to herself there are two staff nurses and two auxiliaries on duty who divide into two teams, each taking responsibility for the patients on one side of the ward.

<sup>29</sup> A staff nurse who is new to, and therefore unfamiliar with, the ward.

patients, and they find [that] very difficult too, without the good guidance and support that they require. And of course the person that's supposed to be giving them the guidance and support's in exactly the same position, is shattered. And lack of experience, we've got a lot of senior staff who haven't got a lot of experience at the moment so they are also trying to deal with their incompetencies. But they're not incompetent, but you know, their insecurities, trying to support all these new people and it just doesn't work. (Gemma: 871-879)

As a staff nurse with four years experience, Maria has experienced this situation at first hand:

the ward itself has always been short staffed. You've got a high turnover of staff and the people who stay there felt as if the pressure was on them. I mean you are newly qualified but practically, [you've] been here six months and you're telling the new start how to do a lot of stuff that you don't really know how to do yourself because there was no support and no guidance from above, or very little. And the ward was total chaos. I mean it was just so busy and I didn't like it at all. (Maria: 60-67)

The lack of support and guidance available for junior staff has serious implications for standards of patient care. For example, the nursing advisor to the Health Ombudsman claims that most of the complaints that she sees reflect a lack of adequate supervision for students, HCAs and junior staff nurses (Akid, 2002). This argument is supported by a MORI poll that claims that one third of students have been left in charge of patients in the absence of registered nurses or doctors (BBC, 2003e).

The pictures which participants paint show nurses working in situations where they feel stretched beyond their limits in terms of both their workload and their experience and knowledge. Lesley describes how working in such a difficult situation damages not only peoples' ability to nurse holistically, but also to support each other.

in terms of looking after one another, I think we're absolutely toiling to look after our patients at times let alone physically reaching out to other nurses who are *clearly* not coping. That's my feeling on the wards this past couple of weeks.<sup>30</sup> (Lesley: 971-982)

Even in a stable team, the maintenance of team cohesion may be compromised through exhaustion and a lack of time for team building. Christine recognises the

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<sup>30</sup> Although Lesley claims to have left nursing and has set up her own business, she continues to work occasional shifts in her old department. The tendency for nurses to continue working after 'leaving' nursing will be explored further in chapter six.

need for her team to know each other and develop as a unit and describes how she has attempted to address the problem:

Christine      in nursing just now there isn't enough time spent on getting to know your colleagues as people. People are moving around so much that, like the last ward meeting, I just made an executive decision to have it in my house so people could have a glass of wine, and have something to eat. And actually because of the new staff, I don't know when they're getting married, when they're moving house, you know, all these kind of things because you are so busy, the minute you come on that's you in your professional roles and you all don't even have the chance to even pass the time of day with each other hardly.

Alison          And does that affect the ability to work as a team?

Christine      Yes. And I think that because there has been so many changes, and there isn't so many senior people around, the staff don't feel supported, in which case that's when you get a bit more back biting, and sort of the team generally unrest and has led to people leaving because they feel unsupported. (Christine: 565-580)

For the nurses cited above, the problem is not simply one of fulfilling an unrealistic ideal. Their accounts show how difficult nurses sometimes find the challenge of reaching even a basic standard of care. The contrast between nurses' high ideals and their experiences sometimes creates a situation in which it is their idealism that prompts the desire to leave. For example, Jane is planning to leave nursing and retrain as a doctor partly because her experience of the reality of nursing is so far from the ideal of holistic, patient centred care she developed in college.

Jane            I think a lot of it's to do with your idea of what nursing should be and how you were taught at college to *be* a nurse, which is probably an ideal setting, and then you've got out into the world which just isn't like that. And it's really difficult to make it like that, to *be* a nurse the way you've been taught to be a nurse.

Alison          So what sort of things are they teaching you there?

Jane            About individualised care and then different ways of carrying out care like 'named nurse approach'. It just seems to be task orientated, no matter how they try and get away from it, it is task orientated and we were always taught to stay away from that and, plan care individually and autonomy for patients (sighs) (Jane: 589-602)

Her story is almost identical to that published by a medical student who left nursing because she consistently saw nurses in situations where their knowledge was equal to or even greater than that of their medical colleagues but they were unable to contribute to the decision making process (White, 2002). Margaret is planning to leave nursing for similar reasons, and Jean has already done so having decided that she is no longer prepared to accept the personal costs of a job that brings her little satisfaction and a constant sense of frustration and fear.

From the accounts cited above it is possible to see where participants' feelings of anger, frustration and fear originate. Although the role they seek to fulfil depends upon a lack of clear boundaries, the necessary overlap with other occupational groups creates a situation in which it is difficult for them to limit their workload. The constant nursing presence and the lack of clear boundaries means that there is often pressure to take on other groups' responsibilities. For example, there is pressure to carry out cleaning tasks since the introduction of competitive tendering in 1983 led to reductions in the number of cleaners in many hospitals (Butler and Batty, 2001; Davies, 2005), or to perform medical procedures since junior doctors' hours have been reduced. This adds to the increasing workload experienced across the NHS described in chapter one. An increasing workload is compounded by nurses' real and perceived powerlessness to influence the organisation of healthcare that clashes with their own aims and ideals. In the following section I explore how nurses seek to negotiate boundaries against a background of constant change and conflict.

## **NEGOTIATING THE BOUNDARIES OF NURSING**

### **NEGOTIATING THE BOUNDARIES OF RESPONSIBILITY**

Nursing exists as part of a complex web of relationships and structures that are constantly changing and being renegotiated. The boundaries between different working roles in healthcare have continually shifted over the years. For example, taking blood samples was once the province of doctors and some specially trained nurses but, in some areas, HCAs are now carrying out this work (Meadows et al, 2000). Surgery was once limited to doctors, but in 2000 Manchester University began offering a course that enabled nurses to become surgeon's assistants, and even to run their own minor surgery clinics (Farrell, 2000). In Plymouth in 2003,

nurses were recruited as surgical assistants to provide additional cover following the reduction in junior doctors' hours, and performed minor hernia repairs (Kenny, 2003).

Nursing constantly engages in negotiations regarding the development of the role of the nurse. This can be seen from the earliest days of modern nursing since the success of the nursing reformers of the late nineteenth century depended, in part, upon the need for paid carers created by the rise of hospital-based medicine. Nightingale and her peers did not simply develop and implement their vision of nursing in isolation from the rest of the world. They were supported and challenged by politicians, doctors and other groups with an interest in hospital-based healthcare and a concern to develop their own interests. Baly points to this process in her claim that:

Nursing developed, not by evaluating the nursing needs of the community ... but often by taking on tasks that other workers no longer wanted (Baly, 1991: 75)

The same process can be seen today in the debate surrounding the relationship between a reduction in junior doctors' hours and the expansion of the nursing role.

Individual nurses also need to negotiate boundaries in response to the dynamic situation in which they work. While a lack of clear boundaries is integral to the role described by participants, it creates several problems. First, as Jean and Christine have shown above, it is difficult to say 'No' when asked to perform activities that under other circumstances one has accepted. Second, there is the danger that, since nurses do not share other groups' clear lines of demarcation, others will define their role for them. Third, nurses themselves are divided over the nature of their role and the way in which it should develop and so do not present a united front in their attempts to shape the future of nursing. However, the lack of clear boundaries can also be exploited by nurses who wish to develop their practice in new directions, or to achieve greater autonomy as practitioners in their own right.

## Setting the Limits

Although the participants in this study have a clear idea of their role and the principles that determine whether or not they should carry out particular activities, the lack of concrete boundaries requires individual nurses to engage in constant re-negotiation from situation to situation. Failure to set limits creates the risk of excessive workloads and it can also create confusion regarding the extent of a nurse's responsibility as Lesley's experiences demonstrate.

As a specialist nurse, Lesley was expected to develop highly specialised skills and knowledge in her field. Although she enjoyed the challenge this posed, she also experienced difficulties regarding the extent of her responsibilities as the medical/nursing boundaries blurred. As she became more of an expert in her field she seems to have become confused over whether her professional identity came from her nursing or her medical knowledge:

I still feel like a nurse, yeah. I still think like (...) well, whatever I am, sort of whatever I am, a sort of hybrid, hybrid nurse-doctor person.  
(Lesley: 816-817)

At times, she emphasises the unique nature of nursing expertise and her fight to maintain the nursing orientation of her post (Lesley: 281-287), while on other occasions she describes the difference between medicine and nursing as one of degree, with doctors achieving a greater depth in the same pool of knowledge (Lesley: 341-351). Her feeling of being a hybrid seems to have grown as she began to develop a depth of medical knowledge comparable with her medical colleagues. As a specialist nurse she combined nursing and medical roles:

But I've come out at the end of it knowing that that it's quite unique to have had a foot in both camps because you would always, foremost, be a nurse but you had this ability to use a much deeper sense of knowledge for critical thinking and diagnostic judgement and that was often used autonomously. You were not asking other people what their opinion was. It wasn't a team-based decision, [You are] an individual worker, and you have to rely on your own knowledge in order to ensure your patient is safe. So telephone consultations, we had direct admission, discharge powers and the ability to order investigations, you were managing critically ill patients and relatives might phone up and say the patient's unwell and we have to then decide to admit them. Very specialised things and, and we felt a lot of responsibility. (Lesley: 363-376)



Lesley's confusion over the nature of her role seems to have been shared by others at the management level and she was eventually asked to provide cover as a SHO.

On night duty they would have a nurse practitioner instead of a doctor and then one Saturday I was called in because all the SHOs were off sick and they asked if I would come in and cover as the SHO. So it just got into a medical-legal minefield and I felt strongly that I am a nurse. In a court of law I will be judged as a junior doctor in the role as a nurse practitioner and it wasn't a direction that I wanted to go in. (Lesley: 326-334)

Ultimately, when faced with the possibility of switching entirely to a medical identity, Lesley was clear that she was a nurse. However, this clarity only seems to have been reached when her manager labelled the role she was fulfilling as that of a doctor.

At the group level, a failure to establish clear boundaries creates opportunities for other groups to define nursing in ways that conflict with nurses' understanding of their role. This is a particularly topical issue since the current political context has added urgency to a continuing debate over the boundaries between different occupational groups. The NHS is under increasing pressure from an escalating workload and shortages of nursing and medical staff and this has led to formalised attempts to reclassify the roles of healthcare professionals. For example, the Scottish Executive has stated that

Traditional professional boundaries will require to be realigned (blurred) if workforce planning is to be successful (Scottish Executive, 2000: 4)

There have even been suggestions that the roles of doctors and nurses should be combined to create a generic healthcare worker (Caines, in Caines and Gough, 2000). There is a strong move within healthcare policy towards breaking down the barriers between the healthcare professions (DoH, 2000; Scottish Executive, 2000). New forms of training and structures will allow people to move easily from one discipline to another and training in one discipline will be recognised as contributing towards training in another. These plans emphasise the importance of 'flexibility' in the workforce and aim to break down the barriers between different professional groups (ibid.). They can be seen as part of a wider trend within the workplace for bureaucratic organisations to challenge the power of crafts and professions (Braverman, 1974; Lloyd, 1994), reconstructing autonomous and skilled

workers as a body of interchangeable employees who can be deployed wherever and however their employers choose.

The lack of clear boundaries also contributes to conflict within nursing regarding the nature and scope of the nurses' role. Nurses are taking on an ever-increasing range of activities, and this is the focus for much debate. Many nurses see role expansion as a challenge, and an answer to nursing's continuing low status. A UKCC report published in 2000 states that nurses are not taking advantage of the opportunities available to expand their role (UKCC, 2000). Coombes' comments on this finding demonstrate the tension between those who see expansion as a positive opportunity and those who resist it:

Sadly, the report suggests that many nurses are missing out on exciting career opportunities because of an inability to act on the scope of professional practice. (Coombes, 2000: 4)

As Christine's remarks on page 133 indicate, some nurses are uneasy about the expansion of nursing into previous medical territory, pointing to the possibility that they are being exploited as a cheap answer to the economic and organisational problems created by recent reductions in junior doctor's hours. Kate explicitly identifies this as the origin of her own post as a specialist nurse:

Well we're really an in between sort of person, because we're working between medical and nursing staff. Initially the job was created to reduce junior doctor's hours, so a certain amount of your work is akin to being of that nature. (Kate: 14-17)

Others have expressed concerns that, in expanding nursing's role in this way, the subordinate position of nursing to medicine is being reinforced (Scott, 1996). As I have shown, many nurses also have concerns regarding the delegation of 'basic nursing care' such as bathing to untrained staff and the move towards a more managerial role for trained nurses. Liz, a Clinical Manager, voices this concern:

there's no such thing as a menial task in nursing. Putting somebody on the commode who's sick, got drips, drains, in pain, psychologically distressed, is an art, we can't just delegate that to any Tom, Dick and Harry in the street. So we've got to have nurses to be able to do that as well. That's just as important as doing taking bloods, giving IV antibiotics, more important probably (Liz: 732-737)

A similar position is expressed by Crump (1992) who argues that delegation to HCAs will lead to a decline in standards. For Crump, for Liz, and for nurses like them, the expansion of the nursing role into more medical areas, and the delegation

of other tasks to HCAs poses a threat to the 'basic care' that lies at the heart of nursing as they understand it. Davies argues that this also contributes to their frustration since nurses increasingly do not practise nursing, they arrange for it to be done by others (Davies, 1995).

The question of setting boundaries is not only relevant in relation to medicine. Participants also show that there are internal debates surrounding the question of whether some people have left nursing, or whether they have simply moved to a new specialism within nursing. These debates centre on the balance between 'hands on' physical care and the communicative aspects of nursing. For some nurses, work that contains no practical 'hands on' care cannot be described as nursing. This debate is clearest in relation to the status of health visiting.<sup>31</sup> All three health visitors interviewed, Heather, Robert and Claire, see themselves as nurses. However, Heather describes how she received considerable 'flak' on announcing her intention to train as a health visitor (Heather: 203). Fellow nurses told her that she would no longer be a nurse, and her new role was described as 'swanning around people's homes' (Heather: 203-205). This exchange took place some years ago but there is evidence that the dispute has not yet been resolved. In 1998, a report on the regulation of nurses, midwives and health visitors recommended changes that have led to the replacement of the UKCC and the four National Boards by the NMC (JM Consulting Ltd., 1998). This new name no longer explicitly identifies health visiting, placing it under the banner of nursing instead, a move which has caused considerable controversy. As a health visitor, Heather speaks of colleagues who stress the difference between nurses, who do things *to* people, and health visitors who do things *with* them (Heather: 215-217). This argument conflicts directly with her own claim, and the claims made by Robert and Claire that they are still nurses.

A similar issue arises in relation to nurses who move into management. Both Valerie (385) and Emma speak of how a nurse who moves into management is expected to leave her nursing identity and agenda behind.

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<sup>31</sup> Health visitors do engage in some physical tasks such as weighing and immunising children or measuring an elderly person's blood pressure as part of a health assessment. However, the bulk of their role centres on support, teaching and surveillance.

the question was asked of some people, not me, 'Are you a nurse who happens to be a manager, or are you a manager who happens to be a nurse?' and in a general management culture what they're looking for is 'well I'm a manager who just happens to be a nurse' (Emma: 490-493)

This management perspective is also seen among nurses who believe that a manager is no longer a nurse. Liz, who recently made the transition from charge nurse to manager, feels distanced from her former colleagues and describes 'a sense that I've deserted them, that comes across' (Liz: 537-538). She is struggling to retain her identity as a nurse, and to see how she can continue making a difference to the care given on her wards (Liz: 447-451). Her ambiguous position is reflected in the comments made by Maria, one of the staff nurses in her department, who describes Liz as one of the few managers she still considers to be a nurse. Maria bases this conclusion on Liz's continuing involvement in supporting patients and their families and on her continued interest in the nursing staff, as demonstrated by her ability to remember the names of even the most junior nurses (Maria: 744-752).

While Maria sees a continued involvement in support as indicative of continuing to be a nurse, Karen takes a different position. In describing her manager, she demonstrates an uncertainty as to whether he is still a nurse, given his lack of involvement in hands on care:

he feels like he's kind of removed from the actual ward environment now so he's lost actual hands *on* skills but at the same time he has the ability to communicate so well and the caring sense which he fosters ... and obviously it's still nursing from that point ... well I suppose that's not nursing is it?. That's probably just being a jolly nice person (Karen: 858-863)

Heather, Liz, and Karen's accounts point to the lack of clarity surrounding the boundaries of the role of the nurse. The question of whether these three managers have left or have simply moved into another branch of nursing is a highly contested one.

The balance between 'hands on' care and communication in nursing is also an issue for those in clinical practice. Here too, the definition of what is and is not nursing arises. For example, before Margaret trained as a nurse she worked as an auxiliary in a hospice where she developed a belief that the building of supportive, trusting relationships is the key to the nursing role. However, she is currently planning to

leave nursing as her experiences have not matched this expectation. When asked what nursing means to her she replies:

it's just sitting there and maybe comforting somebody who is crying or just realised that they're gonna die. Or it's just listening to somebody's fears about dying. I've only done it a couple of times because you don't get a chance, but a couple of times and I came out and I felt like I'd just done something by being there and listening and offering up my little tuppence worth. I guess that's *not* really nursing because nursing is ... it's all physical, a lot of it. The emotional part is only tiny and I think that's, that's why I'm feeling the way I do, because by the time I get the physical bit over there's not much time left for the rest of it. (Margaret: 763-772)

For Margaret, the balance in her work is skewed so far towards physical care that she cannot reconcile this reality of nursing with the ideal she developed in the hospice. The hard physical labour of nursing prevents her from engaging in the interpersonal aspects that provide her with the greatest sense of satisfaction, leaving her deeply frustrated and unhappy. Although her understanding of nursing fits well with those of the other participants in this study, Margaret concludes that her ideal is '*not* really nursing'. Like Lindsay, Gemma, Elizabeth and Jane, she denigrates her ideal claiming that 'I came in with this big silly view of nursing really' (Margaret: 775-776). These nurses' responses point to the fact that nurses cannot implement their ideals in isolation but have to negotiate their position with other groups within structures that limit their authority to determine their own role.

### Pushing the Boundaries

The internal conflict surrounding the expansion of the nursing role into 'medical territory' points to another phenomenon relating to the negotiation of role boundaries. Nurses do not simply seek to set limits to their practice, they also take advantage of the lack of clear boundaries to develop their role and the scope of their responsibilities. In addition to taking on 'medical' tasks, nurses have sought to develop opportunities for working independently of doctors. This can be seen in nurse led clinics and in the new service provided by *NHS Direct*. This has led to some opposition from the medical profession on the grounds that nurses are not qualified to perform the necessary diagnostic function (e.g. BBC, 2001a; BBC, 2002b). There has also been opposition to the movement of nursing into the higher

education sector on the grounds that nursing is a practical occupation and not a theoretical discipline. For example, the General Medical Council expressed concern over Project 2000 on the grounds that it would lead to nurses being over-trained (Davies, 1995). This opposition can be seen as reflecting doctors' concerns regarding nurses' challenge to their authority. The issue of nurses' authority to determine their own practice is one that I address later in this chapter.

While nursing as a body seeks new opportunities for independent practice, individual nurses also exploit the unclear boundaries of their role, seeking out those areas of practice that offer the greatest potential for pushing the limits. For example, as I show in chapter six, some people choose community nursing because it offers greater autonomy in terms of the lack of surveillance by managers or senior nurses. The new role of specialist nurse also offers scope for those who wish to push the boundaries of nursing and develop their status as autonomous practitioners. In a planning meeting with one of the managers involved in this study, she suggested that I should interview the nurse specialists in her department since they had transformed their role from that of medical support worker, attached to a particular consultant, to patient-focused, nurse specialists working as part of a ward based team. This transformation may indicate that nurses have accepted the new posts because they address the problem of career progression, but that they have then subverted the original medical nature of the role in an attempt to bring it more into line with their own occupational discourse.

The lack of clear boundaries to the nursing role creates both problems and opportunities for nurses and for nursing. At both levels nurses engage in essential negotiations that shape both the nature and scope of their role. However, as I have shown, they are not always successful. In the next section I show how nurses' ability to fulfil their ideal role is thwarted by the situation of nursing within structures reflecting an industrial discourse of healthcare organisation that is in direct conflict with a humanistic ideal of holistic care.

## **NEGOTIATING THE BOUNDARIES BETWEEN OPPOSING MODELS OF HEALTHCARE**

The need to set limits, and the desire to push the boundaries of the role of the nurse, lead nurses and nursing to engage in negotiations with other individuals and

groups. However, as individual nurses, participants describe another form of negotiation in which they attempt to navigate their way through working situations in which they are caught on the boundaries between two opposing discourses of healthcare organisation. The frustration that participants express can be seen as arising from a conflict between the humanistic nursing discourse of holistic, patient centred care, and the organisation of their workplaces that reflects an industrial concern with value for money and efficiency.

Nurses' frustration points to a fundamental struggle to define the nature of the NHS and the status of patients within it. According to the humanistic discourse of the NHS as a service, patients are vulnerable people whose needs provide the *raison d'être* of the NHS. In contrast, the industrial discourse of the NHS uses the language of productivity, efficiency and savings, presenting patients as a series of statistics or objects to be processed in the most efficient manner possible. The emphasis is on an abstract concern with trends and targets rather than the well being of individuals. This is a focus that has led to considerable debate regarding the impact of Trusts' obligation to meet Government targets on patient care (e.g. BBC, 2003f; Sergeant, 2003). In contrast with this emphasis on the dehumanising effect of the industrial model of healthcare, Dingwall and Allen argue that it is nurses' humanistic idealism that poses a serious problem since it is a key reason for their high levels of dissatisfaction:

An over ambitious mandate may be the source of chronic dissatisfaction and poor morale as the profession's dreams are broken on the wheel of its license. (Dingwall and Allen, 2001: 64)

They suggest that the ideal of holistic nursing is inappropriate within the current climate of healthcare, and that nurses should drop the occupational 'myth' of a golden age of holistic care in order to focus on working within the system as it stands (*ibid.*). However, for nurses this is not simply a matter of adjusting their expectations. A deep-rooted concern for other people, and its expression in the holistic ideal, is a deeply held belief that lies behind many nurses choice of occupation, as I demonstrate in chapter six. Furthermore, individual nurses do not have this choice; often they find themselves caught between the humanistic demands of their professional bodies and the demands of an industrial system that treats nurses as workers to be deployed, and patients as units of production.

## **The Origins of Conflicting Discourses of Healthcare Organisation**

This clash of discourses is a relatively new phenomenon since, in the early decades of hospital based healthcare, nurses and managers alike contributed to a system in which hospitals were run upon the same principles as factories. Rafferty (1996) explores this analogy, and shows how the rise of the hospital in the late nineteenth century did not occur primarily as a means of benefiting individual patients as people. Hospital based care grew in response to the needs of the medical profession, and as a tool of the Victorian reformers. In the first instance, hospitals were 'museums' that facilitated doctors' study and practice, gathering cases into one convenient location (ibid.: 24). This is a phenomenon that is particularly clearly described by Donnison in her study of the struggle between doctors and midwives over the hospitalisation of childbirth (Donnison, 1988). In the second instance, the reforming agenda was based upon a dual concern with the physical and moral state of the working classes (Rafferty, 1996). Dirt and disease were perceived as inextricably bound up with morality, a belief that is encapsulated in the phrase 'cleanliness is next to godliness'. Teaching and promoting hygiene were understood to be as important to people's salvation as teaching moral values and self-discipline. Hospitals were places in which the degenerate working classes could be morally and physically cleansed and healed and were run along the lines of a factory with an emphasis on discipline (ibid.). Rafferty concludes that:

Patients' roles developed as an extension of those prevailing in the workplace and involved similar forms of discipline. (Rafferty 1996: 18).

This bringing together of the industrial and the biomedical is, of course, a major strand of Foucault's broader analysis of modernity (Foucault, 1973). Within this factory system, nurses fulfilled a surveillance role as the ever-present eyes and ears of the doctor (ibid.). Nursing was essentially organised around the principle of task allocation, with work being allocated according to the rank and experience of the nurse or student. It developed as a rigidly bureaucratic and hierarchical system, which has survived to shape the experiences of nurses practising today as I demonstrate below.

The dominance of this industrial discourse of healthcare within nursing continued until the late 1960s when the publication of the Salmon Report led to major changes within the organisation of the NHS and the balance of power between different



interest groups. Over the next thirty years, nursing discourse changed radically with the rise of the discourses of holistic care and professionalism; while the organisation of healthcare continued along industrial lines with an increasing emphasis on managerialism.

Prior to the Salmon Report of 1966, nurses wielded considerable authority within hospitals since matrons were responsible for non-nursing functions such as cleaning and catering as well as for nursing services. The Salmon Report challenged this power with the introduction to the NHS of a new discourse of managerialism. This discourse is based on the premise that management is a science in itself with principles that apply to any field. Salmon argued that since matrons were specialists in nursing and not management they should relinquish their control of non-nursing services to trained general managers (Carpenter, 1977). Carpenter argues that there was also a strong element of sexism within the Report in that matrons, as women, were seen as being unsuited to the masculine world of management. Despite the emphasis on the need for trained general managers, the Salmon Report was implemented hastily leading to a situation in which senior nurses who applied for management posts received inadequate training and often struggled to cope (ibid.: 179). This further reinforced the argument that nurses were not suited to managerial positions.

The Salmon Report marked the beginning of a decline in the power of nurses to contribute to decision making at both the local, hospital level and the national policy level. The loss of power that nurses experienced at this time may be linked to the rise of the discourses of holistic nursing and professionalism that occurred from the early 1970s onwards. Both discourses challenge the dominant industrial model and could be seen as the means by which nurses have sought to improve their status and authority since the Salmon Report confined them to the wards.

### **Internal Conflict: Nursing as an Humanistic or an Industrial Organisation?**

Despite the power of the holistic discourse of nursing to shape nurses' expectations, nurses and managers are not clearly divided along the lines of discourse, and many nurses continue to operate from within an industrial, Taylorist model of nursing. Although an adherence to holistic ideals is strong among many of the participants

in this study, and the professional discourse of nurses as autonomous, accountable experts dominates nursing text books (e.g. Morton Cooper, 1985; Kagan and Evans, 1995; Mallik et al, 1998; Pyne, 1998; Hamer and Collinson, 1999), phenomena which have their origins in the industrial discourse, continue to characterise much of British nursing. This can be seen in the bureaucratic structures of nursing, in a strong concern with hierarchy, discipline and rule following and in the continuation of task oriented care in some workplaces. The influence of the industrial discourse over nurses' practise is also apparent since the introduction of Clinical Governance in which nurses like Lesley participate in the development of protocols and procedure manuals. The introduction of Clinical Governance, as part of the New Labour Government's programme of NHS reforms, reflects a bureaucratic concern with improving the quality of care by establishing national guidelines for clinical practice in the NHS. Clinical Governance is 'the process by which each part of the NHS quality-assures its clinical decisions' (DoH, 1998), and is a programme that is being implemented in Scotland (Scottish Executive, 1999), England (DoH, 1999b), Northern Ireland (DHSSPS, 2001) and Wales (NHS Wales, 2001). In England, the National Institute for Clinical Excellence (NICE) was created in order to develop and disseminate guidelines for clinicians, and the Commission for Health Improvement (CHImp) was created in order to

ensure that robust Clinical Governance arrangements are in place locally and that NICE guidance is consistently implemented throughout the NHS. (DoH, 1998)

The equivalent bodies in Scotland are the Scottish Intercollegiate Guidelines Network (SIGN) and the Clinical Standards Board for Scotland (CSBS) (Scottish Executive, 2000). Although professional development is cited as an important aspect of Clinical Governance (DoH, 1999: 6), there is a tension between the soft language of providing 'guidelines', and making research evidence 'available' to professionals, and the role of CHImp in 'enforcing' the implementation of these 'guidelines' (Lilley, 1999: 104). Nurses may be involved in the identification of clinical problem areas in their practice, but Clinical Governance has a clear top down, audit based approach with a focus on standardisation of practice. Clinical Governance is an approach clearly situated within the industrial discourse of nurses as interchangeable workers who follow instructions rather than professionals exercising their own judgement. The prominent role of nurses in promoting and

implementing this programme demonstrates how the industrial, bureaucratic discourse of healthcare organisation exists alongside the professional discourse within nursing.

Nurses' acceptance of new specialist roles can also be seen as part of the industrial discourse in which tasks are allocated on the basis of expertise and grade instead of care being integrated and provided by individual nurses. This tendency appears in Christine's description of her role as a specialist nurse:

[I do the] patient health education, discharge planning, all the bits and pieces that there was a need for on the wards (Christine: 10-11)

Although as an individual, Christine subscribes to the holistic ideal, her post as a specialist nurse is based upon an industrial approach to healthcare that pushes her towards task-oriented practice. Liz recognises the tension between the holistic ideal and the development of nursing organisation along these lines, and describes what she sees as the consequences of such policies using an industrial metaphor:

in fact it's almost becoming a little bit like production line really, 'Oh we'll do this bit, we'll do the bathing, which nurses are more than happy to do and they don't want to hand over lots of these aspects of the work to care assistants. But then the really rewarding bit, when it's all pulled together, is taken from us, and they [the staff nurses] really want to put the icing on the cake. And they're being denied the opportunity, and the rewards that come with it and the job satisfaction. (Liz: 706-712)

Although, as a charge nurse, Sue states that specialist nurses provide patients with a valuable resource, and that they have the time to perform vital functions that staff nurses have no time for, she shares Liz's concerns. She describes how the presence of specialist nurses has led to a situation in which ward based nurses' abilities often go unrecognised. At times they will call a specialist even when they have the skills, knowledge and time to perform the function themselves (Sue: 201-219). This has the dual effect of perpetuating fragmented care and undermining ward based nurses' confidence in themselves, a tendency is that is also noted by Legge (2002). The model of specialist nursing described by Liz and Sue above is essentially Taylorist, reflecting the industrial model. However, descriptions of the role of specialist nurses contained in nurses' responses to Legge's article (*Nursing Standard*, 2001), indicate that conflicting models of healthcare create conflicting expectations of the role of the specialist nurse. According to these accounts, specialist nurses are expected to support and teach ward-based nurses rather than remove aspects of

care from them (ibid.). For these nurses, specialist nursing conforms more closely to the holistic model of healthcare.

The continuing existence of the industrial discourse within nursing is also evident in the work of Hurst (1993) who addresses the deployment of nurses and the organisation of their work. Hurst includes an appendix that provides a detailed break down of the time required to perform a range of nursing tasks, from administering oral medication (one minute), through referring a patient to an occupational therapist (one minute), to fulfilling 'death customs' (five minutes). Hurst's analysis is loosely based upon Roper, Logan and Tierney's activities of daily living, but he uses the activities as a means of dividing nursing care into units rather than as a tool for assessing the whole person's needs.<sup>32</sup> This text is particularly interesting given that Hurst is a registered nurse. As such it demonstrates how conflict between discourses of nursing organisation occurs on the intra-professional level as well as between nurses and other groups.

In describing participants' understanding of their role as nurses I present the dominant discourse of holistic care rather than the complexities and debates surrounding it. While holistic care provides the ideal for all of the participants interviewed, some indicate a level of doubt as to whether this is a reasonable or practical ideal to pursue. The following extract provides a contrast to the entirely negative evaluation of task-oriented care described above. Gemma, while disliking this form of nursing, sees it as a necessary response to working conditions in her department, and so tends towards an acceptance of the *status quo*:

if I'm being honest, I think that [holistic nursing] would just cause [nurses] more frustration because they would be meeting less needs than they can perceive. At the moment they can hardly meet the needs that they feel the patient has and if they could visualise it from even more of a holistic view then I think they would just end up totally burned out. (Gemma: 922-927)

Gemma describes task oriented nursing in terms of a coping mechanism by which individual nurses limit their workload. A similar argument is made by James who argues that a focus on physical tasks enables nurses to argue that they are expected

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<sup>32</sup> The twelve ADLs are often used in ways that divide the patient into a series of problems to be addressed. However, this is far from the original intention of the authors. In a conversation with Nancy Roper in 2002 she impressed upon me the importance of maintaining a perspective on the patient as a whole person when using this model (personal communication, 2002)

to complete too many tasks, therefore limiting what is expected of them (James, 1992). However, when the focus is on 'total care', a nurse is unlikely to feel able to argue that a patient wants too much care and so has no legitimate means of limiting her workload (ibid.). These arguments point to the continuation of a phenomenon, first described by Menzies in 1961, in which task oriented care is one of a number of strategies developed within nursing in order to reduce the amount of anxiety generated by their work (Menzies, 1961).

In the early 1960s, a group of hospitals approached the Tavistock Institute of Human Relations with a request for assistance in developing new systems of staff allocation, since the existing system was seen as being in danger of 'complete breakdown' (ibid.: 96). As Menzies and her colleagues conducted their investigation they became increasingly aware of the high levels of anxiety prevalent among the nursing staff.

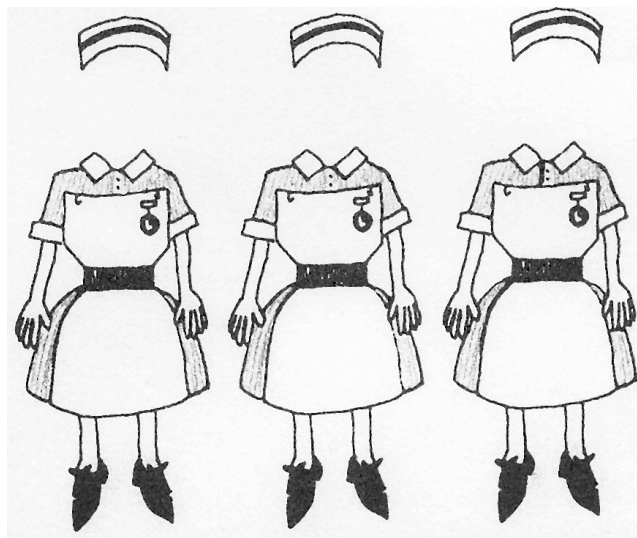
We found it hard to understand how nurses could tolerate so much anxiety, and indeed, we found much evidence that they could not. (ibid.: 97)

Menzies found that while some of this anxiety was due to problems that were specific to the hospital, much of it was linked to the inherently stressful nature of nursing, and the way in which nurses, as a group, had developed ways of dealing with that anxiety. The two key sources of anxiety that Menzies identifies are the close relationships that nurses may build with their patients, and their responsibility for making decisions about patients' care that carry potentially serious consequences. Menzies describes how the former source has led to the development of group coping mechanisms<sup>33</sup> that inhibit the development of a close nurse/patient relationships through the *Depersonalisation* of both parties (ibid.: 12), a strategy that Becker et al (1961) also describe among medical students. Patients are depersonalised when they are identified by their diagnosis rather than by their name, and when their care is broken down into a series of tasks rather than being based in a view of the whole person, i.e. *Task Orientated Care* (ibid.: 11). In focusing on the task, the patient as a whole human being is lost. In a similar way, Menzies describes how nurses are also depersonalised by the wearing of uniforms, frequent moves between posts, and the use of task allocation (ibid.: 12). Instead of being

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<sup>33</sup> I use italics to identify the labels that Menzies attaches to particular group coping mechanisms.

individual people, nurses are transformed into faceless, interchangeable workers, a tendency that is encapsulated beautifully in the cartoon below taken from Salvage's book, *The Politics of Nursing*. (Salvage, 1985, front cover)



Although Menzies work was published more than forty years ago, it still provides some clues as to why the industrial model of nursing persists within nursing itself. The depersonalisation created by these group coping mechanisms mirrors that of a factory based system in which patients are units to be processed and nurses, as Barbara notes, are simply cogs in a big machine (Barbara: 888-890)

These examples show how there is not a simple clash between a nursing and a managerial discourse of healthcare organisation. Nursing has its roots in an industrial discourse that has come into conflict with the newer humanistic discourse. Thus, in seeking to implement their ideal, nurses have to negotiate their way between professional expectations and requirements on one side, and the industrial/bureaucratic structures of both nursing and the NHS. In the next section I show how their success is shaped by negotiations in another key area, i.e., the authority of nurses to contribute to decisions regarding their role and the structures within which they work.

## **NEGOTIATING THE BOUNDARIES OF AUTHORITY**

Nurses' ability to translate their ideals into reality depends upon the power that they hold relative to the other groups with which they negotiate their position. The question of nurses' power or authority to shape their own practice is a strong thread

running through participants' accounts. Feelings of powerlessness are expressed alongside frustration at both the structures that limit nurses' authority and the attitudes that prevent them from using what power they have. In this area nurses engage in negotiations regarding the extent of their authority but they also have to negotiate their way between conflicting discourses of nurses' authority versus their submissiveness and obedience.

### **Discourses of Authority: Autonomous Professional or Doctor's Handmaiden?**

Within nursing there is a strong discourse of professional status that presents nurses as autonomous experts. As such they are capable of exercising their own professional judgement and are therefore accountable for their own practice. Although some nurses have sought professional status since the late nineteenth century, the early 1970s saw a particular rise in the dominance of this discourse of nursing. The Briggs Report, published in 1972, expressed concerns over the level of dissatisfaction among nurses and the potential link with high levels of nurse wastage (Soothill et al, 1996). The state of nursing was of particular concern, given that nurses were the greatest source of complaints to the commission (HMSO, 1972); and one of the key recommendations made was that every nurse should be able to justify her actions on the grounds of research based evidence (ibid.). Following the Briggs Report, the nine existing nursing boards were replaced by the UKCC and four national boards that were given the remit of improving nurse education (Davies, 1995). Carpenter argues that the Briggs Report contributed much to the ideology of nursing as a profession (Carpenter, 1977), and its publication marked the beginning of a period of enormous change in nursing. Nursing research has grown and been incorporated into nurse education to the extent that evidence based practice is now a part of the everyday language of nurses (e.g. Christine: 214; Gemma: 1054). In 1992, with the introduction of Project 2000, nurse training moved into the higher education sector, student nurses became supernumerary and were required to study to diploma level in order to register. Registered nurses are now encouraged to upgrade their qualification to degree level and there is a perception among some nurses that advancement within nursing is dependent upon the possession of a degree (e.g. Mark: 716-717). The introduction of PREP in 1992 also demonstrates the current emphasis on professional development and a culture of

lifelong learning within nursing. The increasing emphasis within nursing on training and updating skills reflects a broader concern in British industry with maintaining and developing workers' levels of knowledge and skill. The NHS has become a part of a broader system of vocational training in which a HCA can study for a Scottish Vocational Qualification (SVQ)<sup>34</sup>, and have her certificate accredited towards training as a registered nurse. Policy makers are now looking at the possibility of an integrated training system that will enable healthcare workers in one discipline to move more easily to another (e.g. DoH, 2000; Scottish Office, 1998). Participants' accounts of their own experiences of studying suggest that the discourse of professional development is not limited to the elite within nurse education and the NMC. For example, Margaret's observations suggest that studying is seen by some as a way in which they can escape the pressures of life on the wards.

everybody's either studying for doing other degrees or they are doing degrees in nursing to get out of the ward and do stuff like palliative care team. But nobody wants to be in the ward forever, or for any length of time (Margaret: 674-677)

For Kate, the motivation to progress in her career was such that she was prepared to fund an entire, distance learning degree course herself, and to study in her own time. The discovery that she was pregnant did not deter her from pursuing her studies.

I had enrolled and then I got pregnant and then I thought 'Well I either drop this degree idea and do it in the future', which would have been *now*, presuming that things would have been easier, or I just keep going. And I thought, 'Is your life ever gonnae be any easier? Probably not'. At that time I was an E grade staff nurse and I knew that I wanted to progress my career, so I thought 'It's not gonnae kill me. I'm young and I'm gonnae manage to do this.' So that's really why I carried on with it. (Kate: 476-483)

Although Kate struggled to combine her commitments to work, family and study, she concludes that: 'it's been a difficult ride [but] it's been worth it in the end' (Kate: 521). As a G Grade specialist nurse she has a significantly better salary than her previous E grade post provided, and she is planning to move into a job share situation that she hopes will help to reduce the burden of her multiple commitments (Kate: 514-521).

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<sup>34</sup> The equivalent in England is a National Vocational Qualification (NVQ).



In claiming to be experts in their own right, nurses challenge the alternative discourse in which they are seen as a faceless mass of interchangeable workers, or pairs of hands to be deployed wherever and however they are needed. This discourse follows the industrial model in which workers are a part of the factory machinery, they are trained to fulfil particular functions and follow the instructions set out by their employers.

The professional discourse inter-links with that of holistic care in that the nurse, as a skilled professional, seeks to develop a therapeutic relationship with the patient. Such a relationship is impossible within an industrial discourse that objectifies both parties. The discourse of holistic nursing also provides the grounds for arguing that nurses have an expertise in their own particular field. This is expressed by participants in their emphasis on the importance of communication and 'people skills'. For example, Margaret complains about the description of nurses as angels, seeing this as a patronising term that emphasises the menial aspect of the work rather than the skill required:

*Ohh! Little angels, it's just so patronising. 'You girls should be paid a lot more' some patients say, 'Why do you do this job? You could be in the police force' and er, like 'Excuse me? I'm looking after you. Somebody has to do it. I don't say that but that's what I'm thinking. Respect me! I'm here looking after you and you, you think I'm mad in the head for doing what they think is a menial job, and not getting paid enough. (Margaret: 576-582)*

Margaret's rejection of the label 'angel' as patronising resonates with Melia's claim that the public's admiration of nurses is based upon a patronising view that the nurse is 'a 'noble soul' doing a dirty job and therefore standing in need of praise.' (Melia, 1987: 155). Margaret, who sees nursing as a highly skilled profession, denies that nursing is menial work. For her, the real skill lies in communication, and the building of therapeutic relationships with patients (Margaret: 412-418, 766-776). This perspective is shared by David who defines a good nurse by her communication rather than her technical skills. He describes the latter as 'something that a monkey can be trained to do', while good communication demands a much greater level of knowledge and skill (David: 48-50). Within this discourse of professional nursing, although a nurse may engage in 'menial' tasks, her work is highly complex, demanding a high level of skill and knowledge and deserving of respect. A nurse is not a worker simply following the instructions of

others, she is a highly skilled and knowledgeable professional who is capable of determining her own practice and who should be respected as such.

This professional discourse of nursing contrasts powerfully with older discourse of obedience and submissiveness described by Mollett at the beginning of this thesis. She states that a new nurse must learn 'the subordination of her will unquestioningly to that of another', showing loyalty to her superiors, knowing her 'right place' and suppressing any questions or suggestions that she might have (Mollett, 1888, cited by Jolley and Brykczynska, 1993: 14). The level of subordination and self-effacement that Mollett expected of her nurses in the late nineteenth century seems extreme when viewed from a twenty first century perspective. Indeed, the need for nurses to be accountable for their actions, has become a professional requirement. For example, a nurse who administers a drug that has been incorrectly prescribed by a doctor, bears the responsibility for her action, since she is expected to have a full working knowledge of that drug, its normal dosages, side effects and contraindications. The NMC *Code of Professional Conduct* states that:

You are personally accountable for your practice. This means that you are answerable for your actions and omissions, regardless of advice or directions from another professional (NMC, 2002: 1.3)

This professional expectation of accountability is not confined to official documents and to the 'professionalizing' elite described by Carpenter (1977) and Melia (1987). Participants' accounts indicate that accountability has become part of the everyday language of nurses (e.g. Elizabeth: 156; Eileen: 274, 283, 916; Gemma: 871, 1287; Heather: 182, 133 and Jane: 608).

In addition to an emphasis on accountability, nurses are expected to act as the patient's advocate, an aspect of the nurse's role that is referred to by Christine (145), Elizabeth (298), Eileen (877), Jane (238), Kate (376), Liz (722) and Margaret (406). Again, this expectation has been enshrined in *The Code of Professional Conduct* (NMC, 2002). A registered nurse must 'act to identify and minimise the risk to patients and clients' (ibid.: 8), including threats posed by the conduct of other professionals (ibid.: 8.2). The advocacy role is not confined to the parameters of the workplace, or the specific nurse/patient relationship.

You must promote the interests of patients and clients. This includes helping individuals and groups gain access to health and social care, information and support relevant to their needs. (ibid.: 2.4)

For nurses who are also managers, the broad scope of their role as advocate is made even clearer.

When working as a manager, you have a duty towards patients and clients, colleagues, the wider community and the organisation in that you and your colleagues work. When facing professional dilemmas, your first consideration in all activities must be the interests and safety of patients and clients. (ibid.: 8.4)

Thus, the nurse, as portrayed in *The Code*, is not only an accountable professional, she has an active role to play in defending and promoting the health of the community as a whole. This shift from 'handmaiden' to 'advocate' can be seen in the recent moves to transform health visiting, placing a greater emphasis on nurses' role in public health.

Although the discourse of professional autonomy and accountability dominates the nursing literature, Nightingale's original emphasis on the subordination of nurses to doctors continues in the ideas of some participants. For example, Margaret describes one aspect of the nurse's role as being 'the doctor's aid' (Margaret: 398), and Valerie, as an American nurse who came to practice in Britain, comments on the extent to which British nurses seem to still see themselves as the doctor's handmaidens (Valerie: 241-254). However, many nurses, like Jane (146-148) reject the 'handmaiden' role and see themselves as skilled and knowledgeable practitioners in their own right. This can create difficulties with doctors who continue to expect nurses to fulfil the handmaiden role as Elizabeth describes:

a lot of the doctors found it very hard (laughs) to accept all these assertive nurses because they expected that we would just do as they said and we would question. (Elizabeth: 288-290)

While the discourse of nurses as autonomous professionals who are experts in their own field has gained a prominent position within nursing, claiming to be a profession does not automatically lead nurses to be accepted as professionals. A nurse's ability to work in this capacity is often hampered by the attitudes and actions of her medical colleagues. For example, Anne's acceptance by her medical colleagues as an expert in her field was the product of years of teamwork in which she had to prove her abilities (Anne: 373-396). Lesley also had difficulties with

medical colleagues and other groups when she was involved in developing a shared system of record keeping:

the professions allied to medicine have a lot of difficulty with the concept of giving up their own notes and protecting their professionalism and whatever and the image of that and the medical staff, I mean senior registrars shouting at you in front of a whole room of doctors, I mean it's all *happened* because we had the audacity to question (Lesley: 223-228)

Like Anne, Lesley found that she had to prove her professional credentials over a long period of time before her medical colleagues were willing to listen to her opinions. Jane also describes a situation in which medical colleagues refused to listen to her when she warned that a patient needed to be transferred to the cardiac unit (Jane: 638-680). Her professional judgement proved to be correct, but as a junior staff nurse she was not taken seriously. For these participants, recognition as a fellow professional did not automatically flow from their registration as nurses.

The combination of a powerful occupational discourse of professionalism, enshrined in a professional code of conduct, and continued perceptions among doctors and others of nurses as handmaidens who simply take orders, creates a situation in which nurses have to negotiate their position carefully. Within nursing they are held accountable for their actions but in practice they may have to fight to be heard by those who hold greater power to determine the decisions that shape their practice.

### **Discourses of Nursing Authority: Maternalism or Empowerment?**

In addition to negotiating the extent of their authority with doctors and managers, nurses also engage in negotiations regarding the balance of power with patients. In describing their understanding of the nurse's role, participants indicate a dominant discourse of holistic care as meeting patients' needs in all areas of their lives. This perspective raises the question of the power balance within the nurse/patient relationship. As Heather notes, this discourse of holistic nursing emphasises doing things *for* or *to* the patient rather than *with* her (Heather: 208-210), a situation in which the balance of power is firmly in favour of the nurse whose attitude could be described as maternalistic. By this, I mean that nurses seem to take the

responsibility for identifying and meeting patients' needs as if the patients themselves were not capable of contributing.

This maternalistic power relationship between nurses and patients is resonant with that described by Gamarnikow who argues that Nightingale and her nursing peers transferred the idealised gender roles and relationships of the nineteenth century directly into the hospital setting (Gamarnikow, 1991). The doctor, as the father was the ultimate authority but delegated much of his authority to the nurse/mother, who was responsible for the running of the ward/home and the care of its inhabitants. The patient/child was a dependant with neither responsibility nor authority. As Nightingale argued, the role of the nurse is to remove all sources of responsibility and concern so that the patient can fulfil her task of healing (Nightingale, 1859 cited by Armstrong, 1983).

This maternalistic discourse of holistic care has been challenged by the rise of consumerism as an integral part of the current phase of development of the capitalist system, and by the rise of the disability rights movement. This challenge has manifested itself in the field of healthcare as a discourse of patients' rights. Within this discourse, patients are no longer expected to accept the role of passive, dependant child. They have the right to know what is being done to them and why, and to decide for themselves whether or not to accept treatment. The influence of this discourse can be seen in texts generated by policy makers and by healthcare professionals. For example, the creation of Patient Advice and Liaison Services (PALS) in every NHS Trust as part of the Government's ten year reform plan (DoH, 2003a). *The Code of Professional Conduct* also reflects this discourse in a lengthy section on the requirement for nurses to ensure that patients are able to make fully informed decisions about their care (NMC, 2002).

While these examples of texts do not necessarily reflect a translation of this discourse into practice, some success is apparent in the changing language of healthcare workers who often speak of 'clients' instead of 'patients', reflecting a relationship based on contracts rather than altruistic service. This may simply reflect the new, commercial language of the NHS that accompanied the introduction of the internal market in the early 1990s. However, for some nurses at least the change in language indicates something deeper. These nurses see holistic nursing simply in terms of viewing the patient as a whole person. This does not

necessarily require a nurse to identify and meet all of the patient's needs. Indeed, in this context, such an endeavour would be seen as intrusive and demeaning to the patient, who has the right to privacy and to be a partner in her own care. This is an attitude demonstrated by Sue who shows a strong resistance throughout her interview to attitudes and structures that disempower both nurses and patients.

It's one of the reasons I think, originally I never wanted to stay working in hospitals because I think I prefer, really to work in an environment where perhaps there's more of an equal balance between you and them. I think you can only do as best you can in hospital but it's very different because, in order to get through your *day*, you have to structure it, you have to coerce (wry laughter) them subtly into having their washes and things and doing things the way you want. But it's not ideal. (Sue: 100-106)

Sue's perspective is shared by Heather who describes a nurse's role as empowering patients (208-209), by Robert who points out that 'no-one can deal with their [the patients'] whole lives' (715), and by Claire, who highlights the right of people to refuse her services if they wish (Claire: 705-716). However, Sue almost left hospital nursing because of nurses' dominance over their patients in that setting, while Heather, Robert and Claire all speak from the perspective of health visitors. This may indicate that there is a tendency for nurses with a more egalitarian approach to holistic care to move into a community setting while a discourse of holism as all-encompassing care dominates hospital nursing. This is a phenomenon that will be explored further in chapter six.

Thus far I have focused on nurses' authority relative to doctors and patients in particular. However, nurses' authority is not simply a matter for discussion, it is also determined by the structures within which they work and the ways in which they view themselves and their position relative to others.

### **Nurses' Authority in Practice**

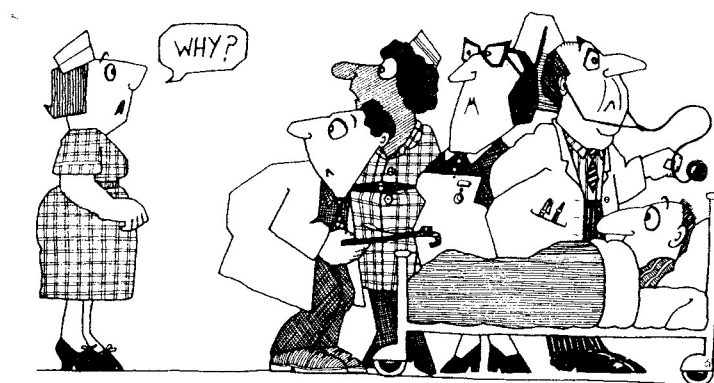
In the light of a powerful occupational discourse of the accountable nurse as patients' advocate, one might expect nurses to be vocal wherever decisions impacting upon patients', or clients', health are made, from the ward or GP practice, through hospitals and Trusts to national policy making levels. However, a closer scrutiny of participants' accounts suggests that, despite the shift of discourse towards professional accountability and advocacy, earlier ideas of the submissive,

unquestioning nurse persist and continue to shape individual nurses' thoughts and actions.

Although Mollett's description of the 'perfect' nurse sounds archaic, elements of it have survived long enough to shape the early experiences of several participants in this study. For example, Emma speaks of the rigid hierarchical ward structure that she experienced during the 1970s in the formative years of her nursing career. If, as a student, she did have any questions, she was expected to address them to the student above her in rank. Questions were passed up through the chain of command:

as a first year you'd never go straight to the ward sister to ask her something, you'd go to the third year *student* nurse first of all  
(Emma: 214-216)

The cartoon below draws upon this discourse of 'knowing your place' in the hierarchy and accepting the decisions of one's seniors without question.



(Salvage, 1985: 11).

For students like Emma, challenging the authority of the doctor and qualified nurses by asking questions would have been extremely risky; progress in one's training depending upon a series of ward reports written by the charge nurses at the end of each placement. Christine, who trained a decade later, speaks of the fear she felt as a student that her desire for answers would lead to a label of being 'awkward' and consequently to a bad ward assessment (Christine: 213-222). She describes how she had to negotiate a position in which she could satisfy her desire for knowledge whilst retaining a good reputation with the ward staff. Sue, who also trained in the 1970s, speaks of the frustration of working in an environment where nurses were expected to accept orders without question. During the mid

1980s she found herself working in just such an environment. I asked what it was about this particular ward that she found so difficult:

Everything. The nature of the nursing, the sister who wouldn't accept anybody that questioned anything and it was just an environment which you did as we were told and there was no real input, and it was very old fashioned (Sue: 571-583)

Sue bases her approach to nursing in an holistic perspective and tries to establish an equal relationship with patients. However, in the quotation above, she points to the difficulties that she has encountered in realising this ideal within a hospital setting. She speaks of her dislike of hierarchies and of power games. The latter are cited by David as one reason why he has seriously considered leaving nursing (David: 136) and Lindsay also uses this phrase in the context of her fear of being seen as weak if she asks for support (Lindsay: 283).

Sue's rejection of the authoritarian and hierarchical nature of this particular ward is indicative of the changes that have taken place over the past twenty or thirty years. Nurses like Sue have challenged the discourse of the submissive nurse, insisting on speaking out and taking responsibility for their own practice. Elizabeth, who trained during the 1980s, speaks of the changes in attitudes that she has observed since that time:

nursing is evolving and changing. When I started you didn't have degrees.<sup>35</sup> That's all changing and I think *with* that is bringing a lot more thought, analysis and that is a *good* thing I think. When I trained it was all so *unthinking* it's just untrue. It's like we were *told* to accept everything and not have an opinion (Elizabeth: 320-324)

However, although the challenge to this particular aspect of the discourse of nursing appears to have had considerable success, not all nurses share Sue's rejection of hierarchy and authoritarianism in nursing, and not every nurse feels free to speak her mind and to ask questions. For example, Kate, who trained in the 1990s, describes this as a difficult period during which she learned that the key to survival is 'fitting in', a common phenomenon among students that has been described by Melia (1987). For Kate, this 'fitting in' involved a lot of hard work and

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<sup>35</sup> This is not actually correct. Elizabeth trained some time in the early 1980s and the Department of Nursing Studies at the University of Edinburgh opened in 1956. However, nursing graduates were, and remain, a relatively rare breed although, since the shift of nurse training into to the higher education sector, nurses are increasingly encouraged to study to degree level.



asking questions (Kate: 137-143). However, there were rules about the type of questions that were considered acceptable. I asked if asking questions was seen as a 'good thing'.

Kate            Yeah, but not questioning practice, just asking general questions about patients, about what you were doing for them, about drugs and whatever but not, you know, not the routine or anything. We didn't question that.

Alison          Right, so 'What should I do?' rather than 'Why are you doing that?'

Kate            Yeah, definitely, that was really part of our training. *Why* you were doing that didn't come into it, I would say, a lot of the time. (Kate: 145-150)

Heather, who was a student at around the same time as Kate, also found that qualified nursing staff discouraged her questions (Heather: 107-112). Although these examples are drawn from a period when expectations of unquestioning submissiveness were being challenged, Kate's reflections indicate how attitudes are passed through the generations, making cultural change an extremely slow process. Indeed, it can take around thirty years for new traditions and customs to become part of an occupational culture since older members continue to pass their ideas onto the following generations until they retire (Hadikin and O'Driscoll, 2000). As a senior nurse now, Kate is suspicious of students' motivation for asking questions, stating that sometimes students ask questions in order to avoid working (Kate: 159-162), and suggests that students do not need to understand the 'Why' of their actions until they are more senior:

as you climb the career ladder you realise you need to know what's behind most things that you're doing, whereas initially I don't think you do.<sup>36</sup> (Kate: 162-164)

While these examples reflect the experiences and ideas of nurses who trained between the 1970s and the early 1990s, participants' accounts of more recent experiences suggest that old discourses die hard. For example, Eileen left one post when a new manager changed the workplace culture from one of collegial co-operation to an 'autocratic system' in which nursing staff were not expected to

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<sup>36</sup> Alternatively, Kate's conclusion could be interpreted as meaning that nurses do not realise the importance of understanding until they are more experienced. However, this exchange took place within the context of a discussion about the appropriateness of students' questions. This would seem to suggest that the former interpretation is more likely to reflect her meaning.

contribute to decision making (Eileen: 240-253). Jane's account of being a student in the late 1990s also indicates that, in some cases, old ideas continue to shape nurse education as well as practice.

I really enjoyed studying. It was a BSc I did so a large proportion of it was science, anatomy and physiology and so on. And I wanted to pursue it further because we'd be learning about something and they would say 'Oh but you don't need to know that' and I was 'but I *do* want to know that' and I used to get quite frustrated. (Jane: 51-56)

Jane's frustration is shared by a student writing in the *Nursing Times* whose experience in 2002 was still one of being 'made to feel like a burden on the wards and chastised for asking questions' (Longbottom, 2002: 21).

Despite the move of nurse education into the higher education sector, and an emphasis on the creation of a culture of learning with the introduction of PREP in 1995, it seems that the discourse of the nurse as a knowledgeable, accountable professional has made little impact in some areas. In conversation with a friend who is a graduate nurse, she described failing an assignment submitted when studying for qualification as a Registered Mental Nurse (RMN). She approached the assignment in much the same way as she had done as an undergraduate, challenging the assumptions underpinning the question. Unfortunately this was unacceptable to her tutor who awarded marks for each point that corresponded with the checklist provided by a model answer. The experiences of this nurse, and of Jane, suggest the survival of a discourse of nursing in which nurses are expected to memorise and regurgitate accepted 'facts' rather than to question and understand. Within this context, asserting one's authority to challenge practice can be a dangerous choice to make. For example, in Jane's experience of asking for a patient to be transferred to the cardiac unit, she faced criticism and anger on all sides. The doctor involved on her own ward resented her questioning of his judgement while the nurse from the cardiac unit was angry with Jane for not succeeding in having the patient transferred sooner (Jane: 638-680). On one side Jane was expected to defer to the doctor and on the other she was expected to succeed in having the patient transferred, even though she had no authority to overrule the doctor's decision. Once again, we see a situation in which a nurse has to negotiate her way in a situation where she cannot win.

While participants are generally clear that a nurse should act as the patient's advocate at ward level and initiate change within practice, the drive to change and challenge practice and policy seems to evaporate at the door of the ward. Nurses' voices are barely heard in the debates surrounding the NHS and, consequently, their needs and opinions fail to shape policy from the hospital to government departments. Sue's perspective on nurses' role within the NHS sums up this tendency:

somehow I think nurses aren't supposed have the big view. They're supposed to have the little view about what they do and you sometimes think if you question other things and wider aspects of it, it's not your place so it's a bit 'know your placeish' in the NHS I think (Sue: 450-453)

Despite a belief that nurses have enormous potential power (Liz: 488-509; Gemma: 1105-1121) there is a sense of powerlessness to change the negative aspects of their working lives that pervades participants' accounts (e.g. Christine: 93-100; Gemma: 974-995; Jane: 258-275; Jean: 176-182; Karen: 415-417; Kate: 223-228; Margaret: 338-342; Sue: 90-106; Valerie: 186-195). For example, although Gemma is a senior nurse with experience, drive, enthusiasm and intelligence she concludes that she has no power to shape hospital policies:

They are making decisions that you have no control over, but if you have knowledge of where they're making decisions and how, I think you feel more in control of what's happening. (Gemma: 985-987)

While Gemma's strategy of attending meetings in order to understand why decisions are made helps her to feel more in control, she continues to have no influence over those decisions and as such her feeling of control is illusory.

For Emma, the important point seems to be that nurses should accept what they cannot control. During a planning meeting for this study, she expressed frustration at junior nurses' unwillingness to accept the status quo and see that she, as a manager, cannot create new posts (personal communication, 2001). A similar attitude is seen in Karen's account of her experiences of 'resourcing' for her hospital<sup>37</sup> (Karen: 391). Her description of the pressure she faces in this capacity demonstrates the frustration experienced by all concerned when wards are

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<sup>37</sup> By resourcing, Karen means taking on responsibility for ensuring that the wards are adequately staffed for the duration of her shift.

understaffed, the impossible situation in which nurses like Karen, and managers like Emma, find themselves, and the shared sense of resigned powerlessness.

Well, I can't make another nurse. There is no nurses in the bank, there's no nurses in the agency'. We went out to [the agency] and the director of the service said we couldn't afford to get another nurse in from that point of view so 'I can't give you anybody'. And a couple of weeks ago, somebody said 'Well if anybody dies tonight it'll be on your shoulders', and I was like 'Well you know I don't really think that's fair'. But then obviously she was frustrated as well. Now I just look at the whole picture and I think 'well that would be nice. It would be absolutely ideal if we could do that but we've got to make the best of the resources that we've got'. (Karen: 377-386)

These nurses both find themselves in an impossible situation. On the one hand, they have the responsibility for ensuring the safe cover of their wards and are faced with the complaints of junior nurses who *are* prepared to speak out at this level. On the other hand, as individuals, they have no control over either the decisions that are made regarding staffing levels, or the staffing resources available to cover the wards. Both appear to have responded to this dilemma by adopting a position of resigned powerlessness. Kate demonstrates this same response to the inadequacy of resources:

really, at the end of the day it disnae matter how hard you try or how much *you* want to look after patients. There are constraints there and whether you like that or not is irrelevant because these constraints are put upon you (Kate: 210-215)

None of these three nurses speak of the possibility that nurses, as a group, could challenge the decisions made regarding staffing levels and resourcing. Nurses within the NHS form an enormous body and therefore hold a great deal of potential power. Attridge and Callahan describe this potential as 'numeric power' (Attridge and Callahan, 1989: 48). They argue that this is one of the few sources of power that nurses have access to and that its use depends upon nurses joining forces and overcoming the tendency for division and internal conflict that arises from their status as an oppressed group (*ibid.*). However, the exercise of this power depends upon unity. To challenge the *status quo* is a risk that most nurses are unwilling to take.

While Liz rails against her 'pathetic profession' and nurses' unwillingness to make use of their enormous potential power (Liz: 499-509), Heather's experience of

speaking out has been one in which her colleagues stand behind rather than with her (Heather: 195-198). In so doing they offer their support without bearing any of the risk, but the chances of Heather's success are drastically reduced since she appears to stand alone. As a foreigner, beginning work in a new country, Valerie was particularly struck by what she sees as a desire for invisibility among British nurses:

Valerie        they [the senior clinical nursing staff in her department] had the capability and the knowledge and they always had the clinical expertise but they didn't have any confidence and they tried to be invisible.

Alison        Who were they being invisible to?

Valerie        Management and doctors, so they don't get any hassles.  
(Valerie: 265-272)

This desire to avoid conflict can be seen in Judy's reminiscences of her hospital nursing days, when she would hide in the sluice to avoid confrontations when she disagreed with her seniors (Judy: 211-215). It seems that nurses, as a group, are not simply sidelined by those who make the decisions within hospitals, sometimes they actually seek invisibility, choosing to maintain the *status quo* rather than to risk standing out from the crowd. This is a tendency that has also been identified by Tschudin:

[nursing] suffers from a deep sense of being sidelined and diminished. Indeed nurses seem to glory from such behaviour (Tschudin, 1999: 49).

It may be that this is a case of the Emperor's New Clothes. Most participants think that nurses should speak out, but few are willing to take the risk in case they are not supported. Instead there is a sense that some are waiting to be rescued by a 'knight in shining armour', a tendency that has been noted by Tschudin (1999) and Mackay (1998). Rather than take action themselves, these nurses seem to be expecting someone else to fight their cause. For example, Lindsay sees political activism as something that other nurses, who are better suited to the task, should engage in rather than being the duty of each nurse (Lindsay: 637-639). Judy wants to see change but thinks that nurses of her generation are too 'under the thumb'. Instead she looks to the new generation of students to 'fight causes and things' (Judy: 261-273).

The hope for rescue expressed by these participants seems to be a vain one in the light of other participants' accounts of the influence of nurses whom one might expect to represent their colleagues. The marginalisation of nurses at the level of hospital policy making is made complete in the separation of the roles of nurse and manager described on page 156. These examples suggest the existence of a culture shared by nurses and managers in which it is not acceptable to maintain a foot in both camps; thus nurses who attempt to represent their junior colleagues in management circles are likely to struggle to be heard or seen.

Some participants' connect their perception of a widespread apathy and powerlessness among nurses in practice to a feeling that the RCN is not adequately taking up their cause.<sup>38</sup>

I think they [nurses] should be involved [in political action] definitely. I suppose if the RCN is supposed to be in this role of, the representative of the nurse's voice ... I don't know how accurately they reflect the true voice I have to say (Elizabeth: 316-318)

Elizabeth's feeling that the RCN does not really represent nurses is shared by Gemma (1131-1137), Jane (267-270) and Kate, who sees the RCN as out of touch with nurses on the 'ground floor', describing the nursing unions as 'a waste of time' (399-406). Liz thinks that the current focus on wages totally misses the point of nursing's current problems (702-704), while Sue, who was politically active earlier in her career, has left the RCN, which she no longer sees as speaking out on the issues that concern her most.

I don't belong to the RCN because in the '70s, early '80s there were the strikes in London. I remember marching around Shepherd's Bush in demand for better pay at the time, and I was very disgusted with the RCN and their pathetic stand<sup>39</sup> (Sue: 355-363)

For Sue, what she perceives as the failure of the RCN seems to have left her without a structure within which to voice her dissatisfaction. This perception that the RCN does not represent nurses is important in that it should provide one of the few ways in which nurses who do wish to speak out are able to do so in the knowledge that

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<sup>38</sup> The RCN is a professional body rather than a union but is the main organisation representing registered nurses in the United Kingdom. A smaller number are members of UNISON which tends to recruit more from support staff and psychiatric nurses.

<sup>39</sup> The RCN has a long-standing policy of not taking strike action that is not shared by the other unions representing nurses.

they will not be alone and unsupported. For those who wait for rescue, participants' indicate a belief that this particular 'knight in shining armour' is unaware that there is a cause to be fought, and has not yet mounted his horse.

These descriptions of a reactive rather than proactive stance among nurses echo the work of Rafferty, who claims that in the early years of the health service there was 'very limited participation of nurses in the determination of nursing policy' (Rafferty, 1992). She describes how the RCN's concern not to be considered as a trade union contributed to a reluctance to take action to improve the pay and conditions of nurses during this period, and contrasts nursing's lack of effective action, with that taken by bodies representing the medical profession. This lack of effective action has contributed to the further erosion of nurses' influence over policy at both the local and national level. Owens and Glennerster (1990) demonstrate this decline: under the structure established by the Salmon Report, nurses continued to be responsible to nurse managers; however, the Briggs Report that followed in 1972 was seen by nurses as undermining their authority since it made them responsible to non-nurse managers for the first time (ibid.). The removal of nurses from positions of authority was intensified by the Griffiths Report, published in 1983, which sought to replace professional control over decision making with a culture of managerialism (ibid.). Davies describes this report as deeming nurses to be 'monumentally unimportant', ignoring them apart from a 'whimsical reference' to Florence Nightingale (Davies, 1995: 163). Although under the present Government, nurses have been included in task teams established to find solutions to the current workforce problems (Lipley and Dinsdale, 2000), the RCN complains that the Government has not kept its promise to ensure that nurses are represented at the 'top table' of the new Strategic Health Authorities (SHAs)<sup>40</sup> (Salvage, 2002; Duffin, 2003). This situation, combined with a reduction in the portfolio of the Chief Nursing Officer prompted the RCN Deputy President to complain:

I believe the chief nursing officer position has been greatly undermined ... People seem to be saying to nurses: "Run along little

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<sup>40</sup> SHAs are responsible for co-ordinating and ensuring the effective delivery of healthcare services. Twenty eight SHAs were established in 2001 and came into their full powers in October 2002.

girls and the big boys will stay at the top table." (Buchanan, cited by Duffin, 2003: 7)

Furthermore, as Emma's comments on the expectations of nurses who become managers indicate, the representation of nurses' voices within the managerial structures of NHS Trusts continues to be minimal. The power imbalances between medicine and nursing intensify this situation, as can be seen in nurses' struggle to make themselves heard above GPs in the Primary Care Groups (PCGs) that shape the delivery of primary healthcare services (Willis, 1998; Ryan, 2000b).

A widespread sense of powerlessness among participants, and a resigned acceptance of the *status quo*, seem to clash somewhat with their expectations of themselves as accountable nurses. There appears to be a strong desire among participants for change, without the will to make the necessary challenge to those who currently hold the purse strings and make all of the decisions. This discontented acceptance of the *status quo* has been noted by Davies who cites an extract from her own research diary:

Nurses don't want a reform of education... they want a root and branch reform of the nature and conditions of nursing itself! (Davies, 1995: 3)

She then comments that 'the fundamental discontents of nurses ... have not been addressed in any way' (ibid.), and that nurses have been marginal to the debates surrounding reform. She challenges the assumption that nurses are their own worst enemies, a description that is used by Mackay (1989), Soothill et al, (1996) and Hampshire (2000b), and have been sidelined because they have failed to speak out. Instead, she attributes the marginalisation of nurses to the way in which the bureaucratic structures within which they work, and the society within which they live, are based on masculine assumptions about the world, that relegate women to supporting roles, silencing their concerns.

While Davies focuses on gender in her analysis of nurses' acceptance of the *status quo*, their passivity can also be seen as reflecting Menzies' description of the way in which nursing is structured in order to reduce its members' anxiety. According to Menzies (1961), the transformation of individual nurses into interchangeable workers serves to reduce the anxiety inherent in decision making as well as creating



a barrier to the development of strong nurse/patient relationships. *Ritual*<sup>41</sup> ways of performing tasks (ibid.: 15) and *A Uniformity Of Actions And Appearances* (ibid.: 12-13), achieved through the wearing of uniforms and the development of blanket protocols, reduce the need for individual nurses to take responsibility for decision-making. The responsibility is further reduced by *Checks and Counter Checks* of the smallest decision, made by several nurses (ibid.: 16). Menzies also describes a system of *Collective Redistribution of Responsibility and Irresponsibility* based upon a complex system in which nurses split off the irresponsible side of their personality, and project it upon those below them in rank (ibid.:16-17). Senior nurses are perceived as being responsible and so there is an *Upwards Delegation* of responsibility (ibid.: 20), while juniors are seen as irresponsible and have decision making opportunities taken away. Thus, the responsibility for decision making is diffused across the ranks, and shared to such an extent that 'responsibility is not generally experienced specifically or seriously.' (ibid.: 19). Once again, the continuing discourse of the passive, obedient nurse seen in participants' accounts suggests that these group coping mechanisms have survived into the twenty first century. This continuation of the industrial model of nursing serves as a further barrier to the possibility of nurses speaking out and challenging the *status quo*.

In the light of Davies' and Menzies' work, participants' resignation to an unacceptable *status quo* becomes more understandable. The organisation and effort necessary to overcome such structural obstacles would be immense. This is a challenge that seems beyond the realms of possibility for members of an occupational group that is largely exhausted, divided and demoralised, and that operates within a discourse emphasising strength and coping over challenge and change, as I demonstrate in chapter five.

## **WORKING ON THE BOUNDARIES**

### **Living with Fear**

As Menzies noted in the early 1960s, nursing is an occupation that generates a great deal of anxiety, simply because of the nature of the work:

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<sup>41</sup> As on page 167 I use italics to identify the labels that Menzies attaches to particular group coping mechanisms.

the work situation arouses very strong and mixed feelings in the nurse: pity, compassion, and love; guilt and anxiety; hatred and resentment of the patients who arouse these strong feelings; envy of the care given to the patient (Menzies, 1961: 5)

In addition to the anxiety created by working closely with people in distress, participants describe how they also live with the constant fear generated by working within a context of unclear boundaries. Their experience is often one of uncertainty and, at times, conflict in which they may lose whatever they choose to do. For some, fear becomes a constant companion that does not remain behind at the end of a shift. For example, Anne describes how, as a night nurse, she lived with the fear of making mistakes through sheer tiredness (Anne: 542-555). Extreme tiredness is not only an issue for night nurses. Meadows et al (2000: 34) claim that over 70% of nurses participating in their study said they were mentally exhausted after work. In Jean's case, the constant fear engendered by working in a situation where she felt she had a high level of responsibility, but little or no control, contributed to her decision to leave. She describes how her team changed on a daily basis, making it impossible to meet the responsibility that she carried for her caseload:

I was only getting to see patients if somebody had made a mistake, or somebody had done the wrong thing, and I was the one that was to go in. I thought 'I don't like this.' I don't mind taking responsibility for *my* mistakes or, if I'm working with a team, but it was going in and having to take responsibility for , for things that I had no way of knowing. (Jean: 187-192)

Some of the nurses for whom she was responsible were newly qualified and had been given responsibilities far beyond their level of experience, leading to a situation in which they covered their mistakes for fear of being disciplined (Jean: 198-208). Mistakes were only discovered when patients and relatives complained and Jean found herself 'trying to defend the indefensible' (Jean: 207-208). During this period she lived with the daily awareness that 'there was just an accident waiting to happen because you had no control over anything' (Jean: 181-182).

We've had *so many* near misses. One of these times it's gonnae be real and *I'm* gonnae be the *named* person. It may have *nothing whatsoever* to do with me but *I* am the named person. It's not gonnae go to my *manager*. It's not gonnae go to the person that did it. It's gonnae be *me*. (Jean: 1309-1312)

Jean's account suggests a discourse in which the official allocation of responsibility is emphasised over the influence of the circumstances within which a nurse works. Jean expected to be held accountable and to be disciplined, regardless of the unreasonable position in which she had been placed. As a district nursing sister, she was faced with carrying the responsibility for a fragmented group of nurses whose abilities she could not be certain of, working in patients' homes where she could not directly supervise the work that they were doing.

While James' team were at least working in the same physical location, as a charge nurse, he also found that he had no way of meeting his responsibilities due to problems with both staffing and resources.

James            basically I was responsible for a unit that was understaffed, that was required to run on a twenty-four hour basis and if there weren't staff for twenty-four hours cover then I had to fill in that gap and I was going on a day-to-day basis, knowing that if anyone was *unwell* or people had taken annual leave then we were operating on a very insecure environment where if anything went wrong the buck would stop at my door and I wasn't very happy with that.

Alison           So you had a huge amount of responsibility but not the resources to actually meet it?

James           No.<sup>42</sup> (James: 161-173)

Like Jean, as the team leader responsibility ultimately lay with James, regardless of whether the load placed upon the team was reasonable or not. Frances also points to this difficulty of having responsibility without authority.

[If] a doctor decides that we can fit a ninth person on our ward, the chances are that we will probably find a space to fit that ninth person in, whereas if a nurse says, 'no we don't have the staffing for nine patients', it probably isn't listened to in the same degree. (Frances: 175-178)

In the cases cited above, participants seem to be in situations where they are required, and indeed wish, to provide a high standard of care, but do not have the means to achieve that goal. They can neither refuse to accept increases in their workload, nor control the resources that they need to meet their responsibility. This is an issue that is raised by Davies who comments on the problems created for nurses when the discourse of being a professional emphasises their personal

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<sup>42</sup> James' non-verbal communication indicated that his 'No' was meant as an agreement with my summary of his situation, i.e. 'No' he didn't have the necessary resources.

responsibility without reference to the context within which they work. She asks 'can staff be accountable for situations where they have little control?' (Davies, 1995: 136). Although the logical response to this question is 'No', this does not prevent nurses from feeling responsible and, as Mackay points out, it is nurses' feelings of responsibility which matter more than their actual responsibility (Mackay, 1989).

From the accounts cited above it seems that many nurses find themselves in a no-win situation. They try to reach an impossible benchmark, often without the necessary resources, and with no control over the volume of work that is expected of them. A belief that patients, as vulnerable people, deserve not only a high standard of physical care, but also the emotional support of a familiar and trusted nurse, leads nurses to work themselves incredibly hard. Against this background, the high levels of sickness and emotional problems described in chapter one seem less surprising.

### **Frustrated Expectations**

In their accounts of nursing, participants describe their frustration at being unable to 'do the job'. Conflicting demands and structural obstacles prevent them from fulfilling their expectations both in their day-to-day practice and in their professional development as nurses. Despite the enormous emphasis that has been placed on professional development for qualified nurses, and the achievements of some participants, the accounts of many suggest that the rhetoric of a culture of learning may not always match the reality as experienced by practising nurses. In Jane's case, a desire to learn more and to take on greater responsibilities than nursing offers led to her decision to leave and begin medical training. Like Jane, Mark has a strong drive to learn and find new challenges; as a staff nurse he completed a diploma in counselling, studying part time and paying for the course himself.

that was the most stressful year of my life because I was working full time, I'd just got an E grade as well so [there was] a big step up with responsibility. I then had to do two days a week doing this counselling diploma *plus* I had to work up one hundred and fifty

hours of client workload.<sup>43</sup> So I was literally running from work to go to see my clients. It was just constant, constant. (Mark: 49-55)

Having taken a break from studying for a while, Mark then decided that, if he was going to be able to progress in his career, he would need to study for a degree. However, he was unwilling to repeat his previous experience of studying, concluding that 'it's not good for my health' (Mark: 74-75). He could not see any way of fulfilling his ambitions while remaining in nursing.

in order to be more specialised you've got to do so many more specialist qualifications and you don't get funded for them generally and you don't get the time off to do them that I just thought 'Yeah, lets go somewhere different.' (Mark: 1148-1151)

Mark's reflections demonstrate a problem experienced by many nurses. The rhetoric of professional development has raised their expectations and creates pressure to engage in further study, but an absence of support from some employers creates a serious obstacle to achieving their goals. An Audit Commission Report in 2001 showed that over 50% of nurses were unable to obtain either funding or the necessary release from work to attend courses (Audit Commission, 2001). Other nurses with whom I spoke informally reflected this experience. For example, during one of the recruitment meetings, an animated discussion arose in which the nurses present complained of their difficulty in obtaining either funding or study leave from their employer. One nurse contrasted her own situation with that of nurses in another Trust where appointments have been advertised as including training to Masters level. Another spoke of a friend working for a charitable organisation, who had received 50% of the funding for her degree from her employer. The general consensus was that a lack of support from their employer led nurses in the Trust concerned to feel devalued and ignored (research diary, 08/05/01).

For Lesley, the problem was not one of funding or study leave, but of a lack of mentorship and support when she reached the 'glass ceiling' (Lesley: 671). As a specialist nurse she was encouraged and supported in her desire to learn more about her speciality. However, nursing did not provide the opportunities that she needed as an outlet for her drive and enthusiasm and, ultimately, she reached the

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<sup>43</sup> As part of his training in counselling, Mark had to complete a set number of hours counselling clients.

same decision as Mark, that in order to fulfil her potential she would have to leave nursing.

where do you go? Where is the next place? I mean when the senior nurse says to me 'You have reached the glass ceiling Lesley, where do you see yourself going?'. Well where is the *pattern* for where to go? I *am* on the glass ceiling. I love my job.. Please don't get me wrong, I adore what I do but the system is what got me down. (Lesley: 669-674)

Liz shares Lesley's frustration, describing a lack of career options that allow her to continue her clinical focus. Having decided to take a manager's post, in the expectation of maintaining her contact with patients, she has been disappointed and talks about her desire to go back into a directly clinical role:

I'd been a charge nurse in total for about eleven years. I was reaching the stage where I needed something else to challenge me. I felt that the [specialist nurse] job ... well that did appeal to me but I felt a little bit too young. I felt I was going out to pasture at thirty-eight. The clinical nurse specialist job ... the person in post wasn't about to retire so I didn't really see any other options. I firmly believed that I could still have half a day in the unit, seeing the newly diagnosed patients and I really saw myself as a well rounded clinical person and I was quite naïve really about the organisation but that was the reason, I felt it was a challenge. (Liz: 399-417)

Liz sees herself as having limited options and further promotion would depend upon a move away from a clinical focus which is unacceptable to her since, in moving up the management ladder, she would no longer be a nurse (Liz: 453-460). Liz has reached what she sees as the upper limit of her career options before she is forty. Gemma, Lesley, Christine, Frances and Kate have all reached the level of specialist nurse by their mid thirties. As Lesley found, career options beyond this level, which allow a nurse to maintain her role as a clinical practitioner, are few. What is a nurse to do when she reaches the 'glass ceiling' with another twenty years or more of her working life ahead of her? This question is even more pressing for nurses like Kate who, as I show in chapter five, do not see themselves as having any options outside of nursing. Although, in recent years, nursing has developed a strong discourse of professional development, it seems that for some nurses, their expectations have been raised without a parallel expansion in the availability of support and career opportunities.

## **CONCLUSIONS**

In this chapter I have described a situation in which nurses work within a role that necessarily has very unclear boundaries. In order to function as nurses, and as people, they have to negotiate with other groups and individuals to determine the scope and nature of their practice. However, their authority to make the decisions and control the resources that shape both their practice and their careers is often unclear or contested. This situation has serious consequences both for nursing as an occupational group, and for the individual nurses seeking to work within this context. Although the holistic and professional discourses have achieved dominance within nursing, their translation into practice has been less successful, creating a situation in which the demand and expectations originating in their occupational discourse of nursing clash with the constraints imposed by the structures and organisational discourses within which they work. While some manage to negotiate the boundaries successfully and find a great deal of satisfaction in their work, many others live with powerful feelings of frustration, anger and fear that contribute to a widespread desire to leave nursing altogether. For some, this frustration is compounded by the conflict that they experience between the commitments they hold at work and those arising from their personal circumstances. In the following chapter I consider the boundaries between nurses' working and personal commitments and show how difficulties in negotiating these boundaries also contribute to many nurses' desire, or indeed decision, to leave nursing.

# **Chapter Four**

## **Negotiating the Boundaries Between Conflicting Commitments**

When a person becomes a nurse, she not only takes on a role that makes intense demands of her during working hours, she enters a world constructed around the idea of total commitment. A good nurse is, by definition, committed to her work. Just as the scope of the nurse's role lacks boundaries, and so expands to encompass almost any activity, a commitment to nursing also lacks clear boundaries, extending beyond a nurse's working hours into her personal time. According to the dominant discourse, a committed nurse does not confine herself rigidly to her contracted hours. She is prepared to be completely flexible, staying late at work, changing shifts at short notice, working extra shifts when asked and accepting unpaid overtime whenever necessary. At times, a committed nurse is also expected to work even when sick and to sacrifice her breaks when necessary. Nursing is not simply understood as an occupation, it is a way of life that is expected to take priority over any other commitment that the nurse may have.

In this chapter I explore the tension between the occupational discourse of total commitment, and nurses' need to combine their work with other commitments in their personal lives. This question is of particular importance in the light of the repeated recommendations that NHS Trusts should implement family friendly policies. I argue that this dominant nursing discourse of total commitment reflects wider discourses of commitment to work that together undermine both attempts to implement such policies, and nurses' willingness to make use of the support that is made available to them. I begin by exploring participants' accounts of this discourse before placing it within its socio-historical context. I then show how nurses are faced with the difficult task of fulfilling multiple and conflicting commitments. In particular I focus on the question of combining a commitment to nursing with a commitment to parenthood since this poses one of the most intractable problems for many nurses, and creates considerable ill feeling between nursing colleagues and between nurses and their managers.



## A TOTAL COMMITMENT TO NURSING?

### A GOOD NURSE MUST BE COMMITTED TO HER WORK

Throughout participants' accounts of nursing, it is clear that none of them fall within Peelo et al's fourth category of nurse (Peelo et al, 1996), but see their work as much more than a job providing a wage. For them it is a service that requires those within its employ to have a deep commitment to caring for others (Judy: 298-303; Barbara: 344-350; Jean: 624-647; Karen 201-207; Mark: 229-239). Anne's reflections on the importance of commitment encapsulate this attitude:

I think people have really got to want to want to do the job. They've got to be really interested and *keen* to carry it through and do what *they* see as the job. I do think you've got to like people. You've got to want to help people, whether it's mental health or just straight nursing or whatever kind of nursing it is you've got to be a people person. (Anne: 910-916)

The expectation that a nurse should see her work as more than a job can also be seen in participants' descriptions of bad nursing (e.g. Jean: 652-654; Claire: 437-449). I asked Margaret what kind of behaviour she finds unacceptable among nurses and she offered the example of a colleague:

she seems as if she's just doing the motions. She's doing the job and she goes home. And she forgets things, *important* things, and she doesn't finish what she's doing, she doesn't carry out things. OK we're all doing it for the money, but there has to be a bit more as well. I don't know, I just feel like she's not enjoying her job she's just *in* doing it. It's something to do and she's away again (Margaret: 198-205).

Participants' accounts suggest that bad nurses are, by definition, those who treat their work as simply a source of income. They find no particular enjoyment in it and are not prepared to give any more of themselves than the bare minimum. This equation between bad nursing and people who see their work as 'just a job' also appears in a letter written by a HCA to the *Nursing Mirror* in which he states that:

I consider my job as more than just a job. I care, it is the fault of the health authority if it chooses people who only want money. (Chalk, 1985)

These examples indicate the existence of a strong occupational discourse in which one of the defining characteristics of a good nurse is a commitment to her work. The concept of commitment carries many different meanings. It is an obligation to be fulfilled or a pledge to be kept; it is something with which a person is deeply

involved and for which they are prepared to exert a significant amount of effort; it is also the holding of something or someone in trust (*Chambers Twentieth Century Dictionary*, 1999). All of these are relevant to nurses who are seen as holding the welfare of patients in trust. Since, as I show in chapter three, patients are portrayed in the dominant discourse as people who matter, nurses have an obligation towards them that goes beyond the basic demands of their contract. The discourse of commitment within nursing includes two key characteristics by which a committed nurse can be recognised. First, she has an obvious enthusiasm for her work and is prepared to put herself into it. Second, she is prepared to prioritise her work over everything else including her own needs and the demands that arise from any other commitments that she may carry. In this chapter I focus on the prioritisation of work over other commitments. In chapter five I return to the question of nurses' willingness to put themselves into their work, prioritising the needs of others over their own.

### **Long Hours and Flexibility as an Expression of Commitment**

In chapter three I focus on the boundaries of a nurse's role in terms of the activities in which she engages. However, nurses also experience difficulties associated with the lack of clear boundaries to their commitment to work. The heavy workload that many bear is exacerbated by a situation in which they frequently continue their work well beyond their contracted hours, often without payment or even time off in lieu of the hours worked (TOIL). The 2003 RCN membership survey shows that, at the time of these interviews, 63% of respondents worked more than their contracted hours, averaging an extra 6.7 hours per week (RCN, 2003e: 32). This figure had risen from the 60% reported in the 2000 RCN membership survey (Ball and Stock, 2000: 22). The frequency with which respondents worked extra hours also increased with 36% working extra hours less than once a week in 2002 (RCN, 2003e: 32) as opposed to the 41% reported in 2001 (*ibid.*: 32); in 2002, 9% worked extra hours on every shift in 2002 (*ibid.*: 32). The 2004 RCN membership survey indicates that this situation had not changed with 63% of respondents working in excess of their contracted hours in the week prior to the survey, and 60% of all full time respondents working more than a forty hour week (Ball and Pike, 2004: 30). The rewards that nurses received for these extra hours in 2002 varied widely: 36% of the

hours worked were paid for, while 40% were reimbursed with TOIL (RCN, 2003e: 46). Of these extra hours, 26% were neither paid for nor reimbursed as TOIL (ibid.: 46). In London the situation was worse than this national picture describes with only 13% of the additional hours being paid for and 38% attracting no reward at all (ibid.: 47). There was also an unexplained gender variation with 21% of men receiving overtime payments at a higher rate as opposed to 10% of women (ibid.: 47). In many cases nurses accept these unpaid hours of overtime without question. However, in 2001 a Scottish Trust experiencing budgetary difficulties asked its senior nurses to work an extra weekend for TOIL (Gilbride, 2001). This group of nurses chose to speak out and refused, arguing that the pressure of work made it difficult to fit in their statutory holidays and so accepting TOIL would be the equivalent of working for nothing.

As one might expect in the light of these examples, the experience of working long hours for no extra return is a common one among participants in this study. For example, Christine states that 'some weeks they get full time work out of me for a part time salary' (Christine: 645), while Sue refers to the wider trend, commenting that 'I think the NHS gets an incredible amount of *unpaid work* from its labour force.' (Sue: 327-346). Both Christine and Sue attribute this situation to the belief that nursing is a vocation and as such the rewards should be seen as intrinsic rather than financial:

I think [describing nursing as a vocation is] a mistake *mainly* because it leads to a way of treating nurses so that a) they're dedicated so they won't *mind* being here an hour late, they won't *mind* not getting paid for it and all those other things which go along with it which I think are totally wrong. (Sue: 284-288)

While Sue stresses the exploitation of dedicated nurses, this situation could not continue without the compliance of nurses themselves. As a working mother, Christine takes some of her work home to do in the evenings. She does this to compensate for having to leave her shift on time in order to pick up her child from nursery (Christine: 685-700). Her reflections on this subject demonstrate how managers do not necessarily have to exert pressure on nurses to persuade them to work long hours for little or no extra reward:

there's a lot expected of you to be doing at home, and doing, kind of outwith your hours, although obviously no-body tells you that you should be doing it outside your hours. (Christine 639-642)

Christine works long hours because she expects it of herself. This expectation suggests that she may have internalised an unwritten rule that a good nurse is prepared to put her work before other commitments and to sacrifice her own time if necessary. Judy also alludes to the presence of this rule. Although she always tries to leave work on time, she worries about her attitude and once asked her clinical supervisor if this makes her a 'bad nurse' (Judy: 658-663). If her colleagues shared her attitude towards work, she would have no need to seek reassurance in this way. The fact that she felt the need to ask the question seems to indicate that she is unusual in her attitude and as such risks being labelled as a 'bad nurse'.

Despite Liz's claim that the 'vocational aspect' of nursing has been lost, as demonstrated in nurses' declining willingness to work extra unpaid hours or to work when sick (Liz: 515), the dominant belief among participants seems to be that nurses should be willing to place the demands of work before everything else. Even those who resent the expectation that they will contribute extra, unpaid hours continue to do so. For example, Emma 'begrudged' working through a weekend, but did so because she didn't have any other plans (Emma: 373-376). Kate expressed her anger at the lack of recognition she and her colleagues received for the unpaid overtime they carried out during a winter flu outbreak. However, her sense of responsibility to her patients and colleagues ensured that she answered the call to work during her holiday, despite the fact that she was sick herself and took several weeks to recover from the experience (Kate: 756-847). Although she believes that nurses should be paid for their overtime, she expresses anger and feelings of having been 'betrayed' by colleagues who chose to continue their holidays rather than return to work during the crisis (Kate: 805). Ultimately it seems that she believes they should have answered the call to work despite the lack of any financial return. However, she also decided to work because, by doing so she could lighten the burden carried by her colleagues during an extremely difficult time (Kate: 799-805). Her feeling of betrayal seems to stem from this expectation of mutual support and solidarity. For her, these nurses demonstrated a lack of concern for the impact their decision would have on those who did work during that period.

In some cases, it seems that participants are prepared to work unpaid overtime because to do otherwise would compromise standards of care and patient safety as

well as increasing the workload carried by their colleagues. However, in others it is less easy to see why those concerned give so much more of their time and energy than they are contracted to do. Mackay (1989) claims that some nurses actively choose a heavy workload but does not explore the reasons for this. Her observation is supported by the accounts of participants in this study who indicate that some nurses work long hours, with few breaks, even when staffing levels and workloads are not an issue. For example, Elizabeth worked herself to the point of exhaustion in order to achieve the standard of care that she had set herself as a newly qualified staff nurse (Elizabeth: 114-127). Early in her career, Maria was also prepared to work long hours for no extra pay or TOIL, and found that, not only had she worked through coffee and lunch breaks, but simply by staying late she had worked eight extra hours in a week, the equivalent of a whole shift (Maria: 86-87). In both of these instances, part of the issue seems to be that those involved were inexperienced and took longer over their work than their colleagues. However, Maria complains that she received no help in getting away on time and nobody told her to leave at the end of her shift (Maria: 70-89). It seems that, for Maria's colleagues, working late was an acceptable thing to do and did not warrant any intervention on their part.

Maria's experiences raise an important point in relation to nurses' attitudes towards long hours. Working unpaid overtime does not simply signify a commitment to give extra time when the demands of work require it. Overtime seems to have a symbolic function, serving as a practical means by which nurses can demonstrate the depth of their commitment. In this light, the fact that Maria stayed could be seen as indicative of a deep commitment, and as such would earn her the approval of her colleagues. Had she left on time with her work uncompleted she would have risked being labelled as an uncommitted and therefore a bad nurse. In staying behind, whatever the reason, she was demonstrating her commitment.

The direct connection that nurses make between working overtime and being committed is particularly apparent in Claire's account of the events leading up to her decision to move from hospital nursing to health visiting. During her time as a staff nurse she worked in all of the departments within her speciality, something that no other member of the department's nursing staff had done. In so doing she developed an expertise of some breadth as well as depth. Her seniors seem to have

seen her as someone with particular talent since she was asked to present a paper she had written as part of a course at an international conference (Claire: 129-131). However, at the time, she was also a lone parent with two children, and as such spent much of her career working night shifts in order to balance the two commitments. For many years she stayed late at work whenever it was required of her, and attended training sessions and conferences in her spare time. To do this she relied heavily on a family member for childcare. When that person was no longer able to take care of her children, Claire could no longer be as flexible with her working hours. She describes what she saw as a significant change in the attitude of her managers and colleagues:

there come a time in my life where I couldn't quite give that commitment. I could certainly give the same commitment in terms of staying hours late because I just *would* and that's it. And I would today, and I *do* today let me tell you because I require to do it in this role too, but in things like going off on trips away, well that was more difficult for me, and I'm *sorry* that it was *perceived* as a *reduction* in my commitment. (Claire: 453-467)

Although Claire demonstrated her commitment through flexibility in her hours, often at a high cost to herself and her family, her extra efforts seem to have been taken for granted. When her circumstances changed, and she needed her employers to reciprocate that flexibility, Claire found that they were unwilling to do so, offering only a post at a more junior grade. Her years of experience seem to have counted for very little and she describes herself as feeling 'deskilled' (Claire: 264-265). Eventually she decided that there was no point in staying in a job where she had no prospects, and in which her knowledge and skills were being wasted. She chose instead to retrain as a health visitor, and the knowledge and skills developed over many years were permanently lost to her original speciality. It appears that in this case, the perception that Claire lacked commitment, based upon her inability to work overtime, overrode the need to retain a valuable and experienced member of staff.

Claire's experiences echo the findings of Marsland et al (1996) who claim that the masculine structures of the workplace favour nurses who follow the male pattern of full time, uninterrupted employment. For those nurses who do not conform to this pattern, career progression is more often horizontal than vertical and may even take a downwards turn when they find that their only viable option is to take a post at a

lower level (ibid.). The 2002 RCN membership survey illustrates this point, claiming that 21% of respondents who took a career break returned to work at a lower grade (RCN, 2003e: 62). The widespread belief that nurses should be willing to take a demotion after a career break is highlighted by the challenge that one nurse poses to this expectation in her letter to the *Nursing Standard* (Ansell, 2000).

Claire is not the only participant who has struggled against the expectation that committed nurses place their work before all else, and are available whenever they are needed. As David notes, 'They would take your body and soul if you let them.' (David: 121). As a father, David places great importance on protecting time for his family and describes how his colleagues perceive him as less committed as a result (David: 115-121).

Although parenthood probably poses the greatest challenge to a total commitment to nursing, participants without dependants also find that nursing encroaches upon their personal life. For example, Christine complains about the difficulties of maintaining any kind of social life (Christine: 629-631), and Jane describes how she finds it difficult to plan anything from a holiday to an appointment with the hairdresser since, 'you never know what shifts you're working' (Jane: 946). Although Jane has to request her annual leave months in advance (Jane: 1044), her duty roster is only planned for three weeks at a time. Her shifts are also unpredictable and subject to change at short notice.<sup>44</sup> Jane has particular difficulty in combining nursing with her commitment to playing sport at a national level. In order to remain in the national squad, she trained during the day even though she was working night shifts. Despite her efforts, she found herself unable to play in an important international match because her charge nurse was unwilling to be flexible with her shifts. She concludes that:

they expect you to have your work and that's it and nothing else and it's not like that at all. For most people their work fits round everything else. For us everything else fits round to work, especially with shifts. (Jane: 933-935)

Although this is not the main reason why Jane decided to move to medicine, it contributes to her general unhappiness with nursing and does nothing to change

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<sup>44</sup> In many cases, a senior nurse on the ward compiles duty rosters. When workloads are heavy this may be a task that is left until the last minute. As a staff nurse I have been in situations where I started a shift without knowing whether I would be on duty or not the following day.

her desire to leave. Her reflections on the difference between nursing and other occupations demonstrate how a commitment to nursing is expected to take priority over all else, even if that means that a nurse has to sacrifice her social life and personal commitments outside of work. The degree of sacrifice involved in prioritising a commitment to nursing raises the question of why nurses are expected to behave in this manner. In the following section I show how high expectations of commitment originate in, and are sustained by wider societal discourses of work and gender.

## **THE ORIGINS OF A TOTAL COMMITMENT TO NURSING**

### ***THE COMMITTED WORKER: ANGLO/AMERICAN. WORKING CULTURE AND THE DISCOURSE OF COMMITMENT***

Although the concepts of self-sacrifice and commitment may seem outdated in the individualistic and materialistic culture of twenty-first century Britain, the language of nursing discourse actually fits well within the present Anglo-American discourse of work.<sup>45</sup> The symbolic connection that nurses make between long hours and commitment also appears in Hochschild's study of an American manufacturing company (Hochschild, 1997). She demonstrates how 'official' company policy that stresses the importance of a work/life balance is undermined by an organisational culture based in this symbolic connection. For example, although the company that she studied prided itself on its family friendly policies, the handbook given to new employees contained statements such as 'Time spent on the job is an indication of commitment. Work more hours.' (ibid.: 19). Its employees made little use of flexible, 'family friendly' working practices and those who did follow the 'Mummy Track', had to forfeit any ambitions they had at work in order to achieve a balance with their family life (ibid.).

As Hochschild indicates, the experiences and expectations of participants in this study are not specific to nursing but are shared by workers in many other fields. In commerce, in industry, and in the public services, people are commonly expected to

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<sup>45</sup> As with many other aspects of British life, our discourse of work is more closely aligned with that found in the United States than in Europe. Consequently, much of the literature in this area conflates the two nations, referring to a common Anglo-American or Anglo-Saxon culture (e.g., d'Iribarne, 1997; Dore, 2000).



demonstrate their commitment by working long hours and placing the demands of work above all else (Brown and Keep, 1999; Sennett, 1998 and 2000). Indeed, in Japan the discourse of long hours and hard work as indicative of commitment is so strong that there is a specific word for death by hard work: *karoshi* (King and McGrath, 2004). The watchword of 'flexibility' that is often used within this discourse of absolute commitment to work means that employees are expected to be constantly available and prepared to move wherever work dictates at short notice. Indeed, an acquaintance of mine working for a major bank was once informed on a Friday that she would be starting work in another city on the following Monday morning. Workers who refuse to co-operate with the demands of their employers, or who voice their own needs, may be labelled as whining and uncooperative and therefore as bad workers (Sennett, 1998). Equally, people working in many fields may comply with the culture of long hours and 'flexibility' for fear of losing their job to a more 'dedicated' or 'flexible' worker (Hochschild, 1997). Such fears are particularly powerful when unemployment levels are high and there is strong competition for work.

This working culture of total commitment expressed through long working hours and 'flexibility' contrasts with that of other countries where long hours and harsh conditions are seen as damaging to productivity as well as being contrary to human rights. In a number of OECD countries, there has been a growing acceptance in recent years of the need to provide better leisure and childcare facilities to staff, and some employers have even limited the maximum hours worked. All of these changes are seen as improving productivity (Leadbeater, 2000). The impact of these other working cultures upon the British workforce can be seen in the legislation imposed upon British employers by the European courts. For example, the shift patterns described by participants in chapter three have had to be altered to meet the requirements of the working time directive, a piece of legislation that Karen refers to directly in her reflections on the difficulties of shift work (Karen: 481-492). It can also be seen in the introduction of programmes such as *Improving Working Lives*. However, the success of such initiatives depends upon changes in occupational discourse within the NHS. Staff must not only have access to flexible working arrangements and support services, they must see these services as appropriate and feel able to use them without the fear of reprisals from colleagues

or managers. Despite the rhetoric of the work/life balance, and enforced compliance with European working directives, British working culture retains its emphasis on commitment expressed through self-sacrifice and long hours. Thus the discourse of a commitment to nursing is not an anachronistic aberration but reflects, and is fortified by, the wider culture of work in the NHS and beyond.

## **FULFILLING A CALLING: PROFESSIONAL AND VOCATIONAL DISCOURSES OF COMMITMENT**

Although the expectation that people will prioritise their work over their other commitments appears in many settings, it is particularly associated with occupations that have a professional or vocational discourse. This connection can be seen in the comments made by Professor Gavin McCrone<sup>46</sup> in relation to a claim that teachers have failed to increase their flexibility at work in exchange for improvements in pay and conditions.

My concern is that there appears to be rigidity. If you ask people in other professions, by and large they don't even know what their contracted hours are. (McKinnon, 2002)

The concept of a total commitment to one's work is at the heart of the discourse of being a professional. Functionalist theorists explain this by emphasising the role that institutions play in society. They attempt to show how the professions achieve and maintain their privileged position through a bargain with the society in which they operate (Rueschemeyer, 1983). This bargain centres on the claim of the occupation concerned to an expert body of knowledge that is of benefit to the whole of society. Professions are granted the right to exclusive control over practice based in that expertise, and in return they agree to implement measures intended to protect the public from exploitation of the trust placed in members of the profession. These comprise strict controls over who can gain entry to the profession, rigorous standards of training, and the development of codes and disciplinary structures in order to control members' behaviour. The concepts of trust and the altruistic motivation of the professional group are central to this theory. In order to be seen as worthy of the trust placed in them, professions stress

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<sup>46</sup> Professor McCrone was Chair of the Independent Committee of Inquiry into the Professional Conditions of Service of Teachers

the commitment of their members to a service ethic. Their commitment is exhibited in the way members take on professional values, ethics and codes of behaviour in all areas of their lives, in and out of the work situation (Jackson, 1970). Belonging to a profession involves commitment to work above all else, and determines everything from one's personal values and aspirations to one's friends and leisure activities (Denzin, 1968, cited by Jackson, 1970). Thus a professional commitment to nursing is expected to go beyond the prioritising of work over all else, shaping one's identity as well as one's behaviour. This is a phenomenon that I explore in chapter five.

The expectation that nurses should prioritise work over any other commitments has direct links to the discourse of nursing as a profession. For example, Emma sees nurses' willingness to work extra hours as a consequence of their desire to be accepted as professionals:

I think for many years, when nursing was striving to prove itself as a profession, I think one of the carrots was 'well professionals don't have a working week per se, a profession is for *life* it's not just for your working week' you know, you read your professional journals outwith your time and study and all these things are ongoing and I just wonder, is there something in there about nursing feeling like this because they were striving with doctors, with lawyers and with all the others to achieve the same professional status. (Emma: 401-407)

Emma offers the example of the junior doctors in her department who express frustration at having their hours limited by the Working Time Directive (Emma: 399-400). This insight into medical attitudes towards work points to the wider changes in society that are beginning to challenge the professional discourse. Her comments also indicate conflict within the medical profession regarding the question of junior doctors' hours since many others have campaigned to have their hours reduced. For Emma, working extra hours is not simply about demonstrating commitment, it is about behaving as a professional. However, her comments can also be seen as indicating a deeper significance to a working week without boundaries. She suggests that nurses accept the lack of clear boundaries to their working week in order to gain acceptance as professionals. Harries Jenkins (1970) describes such behaviour within an occupation as professionalisation. Within this context, a nurse who insists on limiting her work to her contracted hours is not

simply an unprofessional individual, she undermines the professionalizing agenda, and therefore the status of the whole occupational group.

An all-encompassing commitment to, and immersion in, one's chosen field of work is not restricted to the membership of a profession. Commitment is also a key element in the discourse of a vocation. For example, within the context of writing about the concept of a profession, Jackson notes that:

A doctor or priest is always 'on duty' in this sense; his vocation is a twenty-four hours a day, seven days a week, lifetime commitment (Jackson, 1970: 6)

In shifting from the language of 'profession' to that of 'vocation', Jackson serves to illustrate how a strong commitment to one's work is a fundamental aspect of both discourses. Indeed, the overlap between the two discourses centres upon this shared emphasis on commitment. Both a profession and a vocation are understood in terms of a long-term commitment to serving others. Although a professional's salary may be substantial, both discourses stress the importance of the intrinsic rather than the material rewards of the work. This is a characteristic of nursing that I address in chapter six. Within the nursing literature, the discourses of nursing as a vocation and as a profession are seen as diametrically opposed. However, in the shared emphasis on commitment, these two discourses are united. Whether nursing is viewed as a profession or a vocation, the dominant discourse dictates that nurses must expect to work whatever hours are necessary to fulfil their commitment as nurses. In the following section I explore another key strand of wider societal discourse that strengthens those of vocational and professional commitment to work, namely that of a gendered commitment to self-sacrificial caring.

### **A GOOD NURSE IS A GOOD WOMAN: A GENDERED COMMITMENT TO SERVICE AND SELF-SACRIFICE**

Working in an occupation that draws upon the discourses of both a profession and a vocation, the emphasis that nurses place on the need for a strong commitment to their work is not surprising. However, these are not the only discourses influencing nursing that demand a high level of commitment to prioritising work. As Hallam notes in her study of nurses' image, nursing discourse is inextricably bound up

with the discourse of gender and, in particular, the idea that women should sacrifice their own interests in order to serve others (Hallam, 2000).

The existence of a strongly gendered discourse of self sacrificial caring appears as early as the time of the ancient Greeks, who believed that a woman's role in life was to care for her husband and family in the home (Anderson and Zinsser, 1988). Indeed in ancient Greek and Hebrew the same words are used for woman and wife (ibid.: 35). In these cultures, which later exerted a powerful influence over British and other Judaeo-Christian cultures, women were not only seen as physically and mentally inferior to men, they were understood to be morally inferior. The ancient Greeks believed that Pandora unleashed all the evils of the world when she opened the forbidden box, and many influential Christian theologians have taught that, since it was Eve who tempted Adam, women are the source of all evil. For example, in the third century AD, Tertullian wrote:

And do you know that you are [each] an Eve? ... The sentence of God on this sex of yours lives in this age: the guilt must of necessity live too. *You* are the devil's gateway. *You* are the unsealer of the forbidden tree. *You* are the first deserter of the divine Law. (Tertullian in Anderson and Zinsser, 1988: 79)

Christian ideas of women as sexual temptresses, who should be contained and controlled within the roles of wife and mother, survived the Reformation to shape Protestant as well as Catholic theology (ibid.). For centuries, women were taught that they could save their souls by controlling their lustful nature either through a religious life of chastity, or by fulfilling the role of wife and mother (ibid.). The pain of childbirth was, until the late nineteenth century, understood as the punishment carried by women for the sins of Eve (Shorter, 1975). Nuns could escape this punishment by rejecting sex completely and being 'promoted to the dignity of men' (St Thomas Aquinas, cited by Anderson and Zinsser, 1988: 194). This teaching is encapsulated in the following Bible verse,

Yet woman will be saved through bearing children, if she continues in faith and love and holiness, with modesty (1 Timothy: 2:15)

Thus, a life spent in service was not simply an advisable or desirable role for women, it carried a moral imperative. It was a woman's vocation to care for and support others. Only through controlling her base instincts and living a life of service as a wife and mother, or as a nun, could a woman achieve redemption. Although this theology of female salvation is no longer an explicit part of gender

discourses, the underlying ideas of female subordination, of women's caring role and their evil nature persist. For example, Ashley cites examples of texts written by Freud and Maslow, highly influential figures in the fields of health and social science, that demonstrate their belief that women are not only inferior to men but are inherently evil (Ashley, 1980).

Prior to the industrial revolution, the home was also the place of work for many people, and women's contribution to the economic upkeep of their families was seen as normal and right. However, with the industrial revolution came the ideology of separate spheres in which paid work was redefined as a male sphere and was physically moved out of the home (Shorter, 1975; Rose, 1981). The home was redefined as a sanctuary over which women presided, raising children, co-ordinating the work of their domestic staff, and providing the support that their husbands needed in order to function in the masculine world of work. It is this role of wife that provides the template for the paid work that many women perform as nurses, secretaries, clerical workers etc as described by Davies (1995). This doctrine of separate spheres reflected the assumptions of the expanding middle classes who could afford such a lifestyle but, in reality, many women continued to contribute to the family income out of necessity, as they have done to the present day (Rose, 1981). However, the power of the discourse was such that working women were no longer seen as part of the natural order and were subject to disapproval and criticism (*ibid.*). The continued influence of this discourse can be seen in the continuing criticisms made of working mothers and the vilification of single mothers today (Benn, 1998).

The reform of nursing, which occurred in the late nineteenth century, presents an interesting, and apparently inconsistent, blend of these traditional ideas about the place of women in society, with the feminist agenda of extending the sphere of women's activity and influence beyond the home. Gamarnikow notes that:

Nursing appears to embody precisely those aspects of femininity which feminism finds so problematic - passivity, self-sacrifice, devotion and subordination. (Gamarnikow, 1991: 110)

However, she then explains the apparent anomaly, claiming that Florence Nightingale deliberately drew upon the discourse of a woman's vocation to care in her attempts to establish nursing as a respectable job for women (*ibid.*). Nightingale argued that the growth of hospital-based healthcare opened up a new

space for a non-domestic expression of a feminine vocation. In this, she can clearly be located within a broader strand of thinking and activism amongst upper-middle class English women of the period.<sup>47</sup>

Privileged women who wished for a life beyond the home ... would seize upon their duty to be virtuous and transform it into the right to reform society. (Anderson and Zinsser, 1988, volume 2: 128)

As I have shown in chapter three, Gamarnikow argues that Nightingale and her nursing peers transferred the idealised gender roles and relationships of the nineteenth century directly into the hospital setting. Nursing was modelled on the family triad of father, mother and child. It was established as an alternative option to the role of wife and mother, through which women could fulfil their vocation by sacrificing their own interests in the service of others. The modern day emphasis on total commitment reflects both this discourse of female self-sacrifice and service, and the original ideal that nursing and marriage are alternative, and mutually exclusive, options for women.

As an occupation situated within a culture of commitment to work, as one infused with ideals of both professional and vocational commitment, and as an occupation built upon the discourse of female self-sacrifice and service, an expectation of total commitment lies at the heart of what it means to be a nurse. Whether a nurse sees herself as a professional or as a person with a calling, she is faced with the demand for total commitment. A nurse who treats her work as 'just a job', and who restricts her efforts to her contracted hours, may be labelled as unprofessional, as a bad woman, or even as a bad person. In the following section, I show how the discourse of nursing commitment expressed in a willingness to accept long and unpredictable hours and to prioritise work over all else, creates serious problems for nurses as people with multiple commitments.

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<sup>47</sup> Nightingale was a close friend of Elizabeth Garrett Anderson and a contemporary of Sophia Jex-Blake, who both fought for women's right to enter the medical profession (Blake, 1990). At the same time, Mary Carpenter was involved in prison reform (Thane, 1981) and Josephine Butler campaigned for an end to state regulated prostitution (Anderson and Zinsser, 1988, volume 2).

## NEGOTIATING THE BOUNDARIES OF MULTIPLE COMMITMENTS

The all-encompassing nature of the discourse of a commitment to nursing has the effect of pushing aside any consideration of the other commitments that nurses, as human beings, inevitably have. Even the most dedicated career nurse will have commitments beyond nursing that compete for her time and attention, and may even challenge the priority that she places upon her work. For example, a nurse might go through life without ever having children, but she may still eventually find herself in the position where she has to care for her elderly parents. The experiences of Robert and his sister, who is also a nurse, suggest that nurses may be more likely to take on such commitments because of the relevance of their knowledge and skills:

in terms of expectations within the family, I've got elderly parents. They're both in their mid-eighties and *mostly* keep well, but occasionally have seriously unwell phases, and generally the oldest[siblings] will rely on myself and my sister to be much more involved in those situations. Not necessarily in the hands on care, but the communication with the hospital because of the not unreasonable expectation that we'll have a bit more insight into what they're saying and will be able to communicate that to our other brothers and sisters. But also, when my mother was seriously unwell, it was myself and my sister who had to spend the first three or four *days* with her because the other brothers were just a bit too scared. (Robert: 422-423)

For Robert and his sister, these caring responsibilities were of a limited duration but many other nurses return home to what is, in effect, another nursing shift with little support or opportunity for respite. A nurse with dependants at home has to combine the demands of this unpaid care with those of her working role when both make strong claims on her time and may be unpredictable. Nurses who combine their work with a commitment to raising children face a similar situation. In the following section I show how the discourse of a total commitment to nursing has failed to accommodate the needs of a changing workforce that has accepted married women and mothers for more than half a century.

## NURSING AND PARENTHOOD: NEGOTIATING CONFLICTING COMMITMENTS

### The Entry of Married Women into the Nursing Workforce

Although the discourse of the good woman, as described above, feeds into and reinforces that of the committed nurse, gender discourses also challenge and change



those within nursing. One of the key challenges has grown from the feminist movement that contributed to the formation of modern nursing. Although the nursing reformers succeeded in establishing nursing as a respectable occupation for women, it was created as an alternative means of fulfilling the female vocation to care and not a career to be combined with motherhood. The single status of nurses enabled them to operate within the masculine structures of the working sphere described by Davies, unhampered by the demands of children or husband and able to live, in effect, as men. The re-creation of nursing as a respectable, female occupation was such that men found themselves in the unusual position of being a disadvantaged minority within this working sphere. The entry of men and asylum attendants onto the register of nurses was strongly opposed by Ethel Bedford Fenwick, the leading nurse in the campaign for the registration of nurses in the early twentieth century (Rafferty, 1996). Men were barred from the general part of the nursing register until the Nursing Act of 1949 (Royal London Hospital League of Nurses, 2002) and from taking senior positions in nursing until the implementation of the Salmon Report in the late 1960s (Carpenter, 1977).

However, feminist demands for an equal right to work, to earn, and to own property, have combined with the economic pressures of the labour market, forcing nursing to open its doors to married women and mothers. World War One enabled women to work in areas previously reserved for men, thus challenging traditional ideas of women's capabilities and roles. After World War Two, labour shortages led to a situation in which nursing was forced to open its doors to married women and to men, and to allow nurses to work on a part time basis (Carpenter, 1977). These changes were resisted by the nursing elite (*ibid.*) and directly challenged the discourse of nursing as the preserve of single women whose work is their life. In the 1960s, with another surge in feminism, women's expectations of being able to pursue a career increased. In the late 1960s and early 1970s this expansion of women's working horizons combined with an economic recession that forced many women to combine work with family responsibilities.

The impact of these changes on nursing can be seen in the number of nurses who combine work with parenthood. In 2000, two thirds of all nurses had children living at home (Ball and Stock, 2000: iii). This figure dropped to 55% in 2003 (Ball and Pike, 2004: 17), possibly reflecting the aging of the workforce. We now live in a

society in which many women want to work and to have children. Furthermore, a rising cost of living and the recent dramatic increase in house prices mean that many women have to work in order to support their families. They do so within a culture that continues to undervalue 'women's work' as carers, as demonstrated in the comparatively low pay in these areas of work. Several participants speak of how they have to work in order to support their families, and they describe how financial considerations have shaped the posts they have taken on and the hours they work. I explore the role of money in nurses' response to the problems they face at work in chapter six.

### **The Continuation of a Nineteenth Century Discourse of Nursing Commitment**

While the continued influence of feminine discourses of caring supports the nursing discourse of self-sacrifice; the masculine assumptions upon which working structures in the NHS are based have persisted, despite the fact that many nurses are now working mothers. Although there is much talk of family friendly policies and flexible work practices in the NHS, the implementation of such policies is patchy. For example, Meachin and Webb (1996) describe how efforts to recruit mature students have not been accompanied by policies that offer the flexibility and support that students with children need, making it very difficult for some students to complete their training. Although Emma has introduced a more flexible approach to working hours in her department to assist those staff who are parents (Emma: 427-441), this reflects her attitude as an individual rather than policy within her Trust or the NHS. This piecemeal approach to family friendly policies reflects a masculine working culture that coincides with a nursing discourse of total commitment. Furthermore, the continuation of a discourse of total commitment within nursing means that nurses may not wish to take advantage of these policies if they see such behaviour as indicating a lack of commitment. For example, although she had two children at home, Claire tried not to let her personal work impact upon her working commitment at all:

it wouldn't matter what was happening in my life outwith *at all*, and I believe that my commitment to the place was that the minute I walked through the doors I didn't think of anything else, and if I still required to stay late and late and late I would be staying late and there would be no question of that. (Claire: 239-243)

Instead of reducing her hours or changing her shifts, Claire chose to rely upon family support in order to continue working as if she had no children. In effect, she had a 'wife' at home to care for her children. However, when that person could no longer provide the necessary support, Claire could not sustain her two powerful commitments and was forced to change her working patterns to accommodate her family commitments.

A nurse may also be influenced by the hostile attitude of her colleagues towards people who fit their shifts around their families. Several participants speak of the resentment that some nurses feel towards colleagues who request particular shift patterns in order to combine work with family commitments. For example, after the birth of her first child, Lindsay refused to continue working 'on calls'. As a result she was threatened by her senior nurse with losing her job and had to call on her union representative for help (Lindsay: 144). She describes the attitude of her colleagues to herself and other nursing mothers working part time:

- Lindsay      It was just comments like 'Oh we've done this weekend and these part timers don't pull their weight' but as a part timer you actually try and fill in *more work* in your part time hours than you would do if you were full time. So it's a very unjust view but it's a view that's very much thought of by full timers which makes it very difficult.
- Alison      So [there's] a general sense that your family responsibilities shouldn't make any difference to your work?
- Lindsay      Absolutely not, yeah, that didn't come into it. Your family is *your* family and *you* deal with it. So there was no give at all. (Lindsay: 172-173)

Jane echoes Lindsay's observations, describing her single colleagues' resentment at the priority given to working mothers:

[They say] 'Well we're just having to work around them because they've got their children as an excuse to say which days they want to work.' (Jane: 901-903)

Lindsay and Jane's observations reflect a wider perspective on the combination of motherhood and work. As Wolf notes, motherhood is treated as:

a slightly alarming private hobby ... to be dealt with strictly in one's off hours' (Wolf, 2001: 195)

The permeability of the boundary between work and home is strictly unidirectional. The demands of work may pass across to impact upon a person's personal life, but the demands arising from a nurses' personal life must remain contained and invisible within the domestic sphere.

As a senior staff nurse who compiles the off duty roster for her ward, and as a nurse who hopes to start a family in the near future, Karen sees the situation from both sides:

Well it's very difficult because we've got a D grade staff nurse who's a single parent and she's absolutely super. And she asked could she not work more than one late shift a week. Now I think that's a perfectly reasonable request for somebody that's got a young child. She's prepared to come to work, she works very, very hard and if she works two late shifts that's effectively like four days she doesn't see her little boy which is a huge chunk ... And I said 'Yeah, that's no problem at all, we'll get that organised', but then it means that other D grades are going to be working a lot more late shifts and obviously the early shift's always the most popular one. Most of my D grades are between nineteen and twenty five and that means they've got a social life, they've got to consider their friends so they take offence, 'Why is she getting all the earlies?'. I would have been exactly the same at that age as well, whereas now I'm thinking about children myself and then I would *hope* that people would be fairly sympathetic to my needs. (Karen: 497-515)

These extracts indicate that a nurse with children has to balance her need for flexible working hours with the potential consequences arising from the response of her colleagues. Thus, the question of persuading nurses to return to practice after childbirth is one that depends upon addressing the discourse of total commitment as much as upon changing NHS policies.

### **Juggling Commitments: Nurse, Parent and Partner**

For women who combine motherhood with any kind of paid employment, life can be extremely hard. In her study of working mothers, Hochschild refers to this demanding way of life as working the 'Second Shift' (Hochschild, 1989). She describes how women spend their day at work, attempting to maintain the level of commitment and achievement of their pre-maternal days, and then return home to start another shift as a wife and mother. She shows that, despite the rise of the discourse of the 'new man', little has changed in gender roles and relationships in

the home (ibid.). Hochschild's findings are supported by Wolf who argues that even men who believe themselves to be 'new men' and talk of gender equality often do not share the burden of family responsibilities (Wolf, 2001). Socialisation into old gender discourses, and the limitations imposed on the choices available to a couple by socio-economic structures, act against real equality in the home based on a sharing of domestic and bread winning responsibilities (Benn, 1998). Hochschild powerfully describes the impact on women of trying to maintain this double shift in a society that still operates on the principle that work is a masculine sphere, and women's role is to raise children and maintain the home. The double shift can mean that mothers in paid employment work with little opportunity for rest from the moment they wake until they collapse into bed at the end of a fifteen or sixteen hour day.

The impact of such a lifestyle on nurses is conveyed by Christine and Gemma who are both specialist nurses combining their work with motherhood. Gemma describes how difficult this juggling act can be:

what I've found very difficult now is managing lots of different things, especially with children because I desperately try to leave my work at my work. Whereas before I was one of these people who would take work home and I would be at work 'til seven or eight o'clock at night finishing everything off, whereas now I need to be finished at four o'clock, I need to get out the door, then I have to dump work somewhere else in my brain until such time at night as my personal life finishes and I can start again. (Gemma: 372-380)

Gemma speaks of leaving her work at work, but her comments about starting again at night after her 'personal life finishes' suggest that, like Christine, she has rescheduled her excess hours and relocated them to her home, rather than ceasing to work them. In order to fulfil all her commitments, she has to treat all areas of her life as if they are work, allocating each duty a particular time slot in her busy schedule. This interpretation of her words is supported by an informal conversation that I held with her at a later date. We were talking of the difficulties of juggling work and family and Gemma spoke of how she feels that her relationship with her husband has suffered. Instead of the spontaneity of their previous lives, she feels that he has become one more 'thing' to fit into a busy schedule (personal communication, 2001). This experience corresponds with Hochschild's observation that the pressures faced by working parents combining

family and work responsibilities have contributed to the Taylorisation of their private lives (Hochschild, 1997).

While Hochschild's term 'the second shift' creates the impression of a clear division between women's shifts as paid workers and as wives and mothers, Christine and Gemma describe a more complex situation in which the nursing shift carries over into their home lives. Instead of trying to balance two separate shifts, they attempt to break the demands made upon them into smaller chunks, fitting the excess nursing hours between chunks of time allocated to their family commitments. This creates a far more complex juggling act than one involving the balancing of two discrete shifts. Their task is complicated further by the instability of the nursing shift described above by Jane. A nurse who is a mother has to build enough flexibility into her arrangements to allow for times when her shifts are changed or extended at short notice (James, 1992). She also faces the constant possibility that her responsibilities as a mother will prevent her from fulfilling her working commitments. A nurse who has the resources to employ a nanny, or whose family provides childcare, may be able to continue prioritising work; but it is likely that at some point her family responsibilities will come into conflict with the demands of work. For example, I was present when a colleague who worked full time received a phone call to say that her husband was sick, and their nanny had just fallen down the stairs. Despite all her careful planning, she found herself in a situation where she had to leave behind her work commitments to care for her two pre-school children.

This kind of situation confronts many nurses who are parents (Meachin and Webb, 1996), and their seniors who have to provide cover at short notice do not always appreciate their dilemma. For example, Liz speaks of her response to nurses who take time off when their children are ill:

I don't ever say it but there's a voice inside me that says 'You were off last time. Can your husband not stay off this time?' but I can't say that. It's more than my job's worth. (Liz: 595-597)

Although Liz does not give voice to these thoughts, other managers do, creating a situation in which many nurses claim to be sick themselves in order to secure time off because they cannot be sure that their manager will release them to care for their sick children (RCN, 1999a).

Liz's thoughts point to the influence of gender roles upon nurses who are working mothers. In Britain, childcare is generally seen as the mother's, rather than the father's responsibility, and occupations that are defined as 'women's work' are accorded a lower status than those associated with men. Women's career breaks, and the disparity between men's and women's income, often create a situation in which men have reached a higher rank and income than their partners when their children are born. This can contribute to a situation in which, interruptions to the mother's work are seen as less significant than interruptions to the father's work. Furthermore, as Davies argues, the masculine structure of workplaces creates an expectation that a man with children will have a wife to take care of them (Davies, 1995). Thus, when a child falls ill it is likely that both the parents and the father's employer will expect the mother to take time off work. For this reason, a man may find it easier to sustain a strong work commitment after he becomes a father, than a woman will when she becomes a mother. Although, as David has found, men may find that challenging gender stereotypes at work is not an easy option, women face even greater difficulties since they are often in the weaker position when such decisions are made. As Wolf notes:

Certainly, countless couples do both work, and both share the childcare as much as they can, and work hard to find some sort of balance in their lives. It's just that the 'balance' is usually structured around a bottom line that the woman's life is the source of flexibility, and a man's job cannot be touched. (Wolf, 2001: 223)

When viewed through the lens of gender, it becomes apparent that many of the difficulties experienced by participants in this study arise from the failure of nursing, of the NHS, and of wider working and social structures, to adapt in response to the radical transformation that has occurred in the workforce over the past fifty years. Despite the feminisation of the British workforce, masculine assumptions continue to underpin the organisation of work. Although married women have been accepted as nurses for almost sixty years, nursing has continued to operate according to nineteenth-century discourses of femininity that deny their very existence.

## CONCLUSIONS

The concept of a total commitment to one's work lies at the very heart of the discourse of nursing. A good nurse is by definition committed; a committed nurse demonstrates an enthusiasm for her work and a willingness to prioritise it over all else. While work has no boundaries, spilling over into nurses' private lives, their private lives are expected to be strictly contained. These expectations have their roots in an ancient discourse of femininity that is perpetuated by the influence of professional and vocational discourses of commitment and a broader Anglo/American discourse of commitment to work. The impossible choices that nurses who are parents face are shared by many parents who work within structures that have failed to respond to fundamental changes within the workforce. However, the answer to their difficulties does not simply lie in the provision of 'family friendly policies'. For such policies to be effective, the underlying belief that a total prioritisation of work is the defining symbol of commitment needs to be challenged. Until this happens, the implementation of such policies will continue to be patchy, reflecting the attitudes of individuals rather than the organisational norm, and many nurses will feel unable to take advantage of the flexibility they offer. In this chapter I have explored nurses' need to negotiate the boundaries between their working and personal commitments. In this I have focused primarily on those personal commitments that relate to the demands made by family and friends. In so doing I have not considered the phenomena of nurses working through breaks or coming to work when they are sick. These form part of the following chapter in which I move to a focus on the need to negotiate the boundaries of the self. In this nurses make decisions that require them to decide whether to prioritise a commitment to nursing others or a commitment to caring for themselves.



## **Chapter Five**

### **Nursing As An Identity: Negotiating A Commitment Without Boundaries**

In chapter four I described how nurses are faced with the challenge of juggling what is expected to be a total commitment to their work, with the other commitments in their lives. While this task creates serious practical difficulties for many nurses, the discourse of total commitment has other, much deeper implications. In this chapter I argue that a commitment to nursing does not just require a nurse to prioritise work in terms of time; she is expected to live the role, allowing it to shape her identity in and out of work. As a nurse she is expected to demonstrate her commitment to this role in her willingness to sacrifice her own needs in the service of others. In so doing she must have an almost superhuman capacity for physical and emotional endurance. A commitment to nursing is expected to shape individuals' identities in ways that impinge both upon their relationships with others outside of work, and upon their own welfare as vulnerable human beings. The emphasis that is placed on identifying with a role that stresses physical and emotional strength and coping, and the extent to which nursing shapes people's sense of self have profound implications in terms of nurses' ability or willingness to consider leaving as an option.

I begin this chapter with a consideration of the theory of identity before describing the enormous expectations that nurses have of themselves and each other in fulfilling the role of nurse. I then explore the rationale behind these expectations and the wider structures and discourses that shape and reinforce them. I finish with an exploration of the problems faced by nurses who have to negotiate the boundaries between fulfilling the role of invulnerable super-nurse, and their need as human beings to protect themselves and maintain a sense of self beyond the identity of nurse.

## **THE THEORY OF IDENTITY**

In chapter three I focus largely on performing the role of nurse or doing nursing. In this chapter I shift the emphasis to being a nurse which relates to the ways in which playing this role shapes people's sense of identity or of being in the world. In the western world, with its orientation towards individualism, the concept of identity has become a part of our everyday language, through which we seek to understand who we are and where we fit in our society. This concern with identity infuses both participants' accounts of their working lives and the literature that I draw on to contextualise these accounts. The concept of nurses' identity appears explicitly in references to the self and implicitly in the ways that people describe their working and personal roles in life. It also appears implicitly in their descriptions of the expectations, experiences and feelings associated with these roles. The frequency and ease with which terms such as identity and self are used mask the complexity of a concept that can be understood in a variety of ways.

As with so many aspects of nurses' lives, the issue of identity, and the experience of negotiating the boundaries between different roles, is fraught with tension. This tension reflects the competing influence of two main strands of theory describing the construction of the 'self', the psychodynamic and the sociological. These have moved beyond the academic sphere to shape lay people's language and thought and exist alongside the popular idea that people are born with particular characteristics that constitute their 'real self'.

In this section I explore the theoretical work on identity in order to make sense of the many competing ideas expressed in the nursing and healthcare literature and in participants' accounts. These competing theories allow us to identify and understand the tension that nurses experience in negotiating and performing the various roles that contribute to their sense of self. They also illuminate the problems that many nurses have in reconciling the disparity that sometimes occurs between their behaviour and the way in which they view themselves as people and as nurses.

### **PSYCHODYNAMIC THEORIES OF IDENTITY FORMATION**

Psychodynamic theories of identity formation contribute to our understanding of nurses' accounts of their work in the way in which they reinforce popular beliefs in

the existence of a stable core self and the need to be true to this identity (Danaher et al, 2000). However, the focus on internal, psychodynamic rather than social processes, and on childhood rather than adult identity, limits its application in studying issues of identity related to the working lives of adults within complex organisations. I therefore give only a brief description of the essentials of this field and direct the reader to alternative sources that provide more depth. This allows more time to be spent on sociological theories of identity which encompass the influence of society and its expectations on adults as well as the internal processes by which people's sense of self is generated.

Within the field of psychology, the construction of identity is viewed as the internal process by which the core self, or essence of a person, develops during childhood and is thereafter relatively stable. The seminal works in this field which continue to inform subsequent research and teaching are those of Freud (e.g.1966), Klein (e.g. 1932) and Erikson (e.g. 1950). The psychodynamic developmental process centres on the conflicting desires experienced by the child at differing stages of her development and is largely shaped by her early experiences within the family. Although the nature of a child's interactions with others, and particularly with family members, is viewed as crucial, the focus is on the internal world of the child rather than on the role of society in shaping her development.

Although the details of psychodynamic theory are not widely understood among lay people, the name of Freud and the language of the unconscious have moved beyond academic and therapeutic circles to shape the way in which ordinary people understand and speak of themselves and others. The main influence of psychodynamic theory in this study is in the idea that there is a true self that is overlaid by social relationships (Billington et al, 1998), and that a healthy person behaves in ways that are congruent with this true self. These ideas underpin many areas of psychological theory in addition to that which deals explicitly with identity formation (ibid.). For example, R.D. Laing's theory of schizophrenia rests on the assertion that there is a core self which is validated by others and which disintegrates when the individual withdraws from others to protect themselves against invalidation (Laing, 1959).

As well as being influenced by lay conceptions of psychological theory, many nurses encounter these ideas more explicitly when they study psychology during

their pre-registration training or when studying the theory of counselling during subsequent professional development courses. This training in psychological theory thereby builds upon popular ideas of a core identity or 'real me' that is fixed from birth and is rooted either in heredity or in some less physical force such as destiny. This idea can be seen in the belief that a person is a 'born nurse' who has an innate ability to communicate with and care for others (referred to by Mackay, 1989, 1992; Burnard, 1998; Barbara: 371). It can also be seen in nurses' concern to be genuine in their work, offering themselves to patients rather than simply playing a role (e.g. Barbara: 409-423; Margaret: 174-180; Liz: 222-229). This emphasis on the importance of genuineness reflects the holistic discourse of nursing in which the nurse is expected to use her 'self' as a therapeutic tool, a concept that I return to later in this chapter.

## **SOCIOLOGICAL THEORIES OF IDENTITY**

In contrast with the psychodynamic emphasis on identity formation as an internal process, sociological theories describe the development of identity, or of a sense of the self, as an interpersonal process that depends upon our interactions with others. Within this framework, identity is a position that we take up within a social context (Woodward, 1997), and it is 'bestowed, sustained and transformed socially' (Berger, 1966). It is not the unchanging essence of a person but is a dynamic social construct through which people understand themselves, and each other, by the social categories, or roles that they are assigned or take up (Woodward, 1997). As I argue in chapter two, a role such as that of the nurse provides the shorthand for who we are as well as the rules of interaction between people.

It is in these roles that we know each other; it is in these roles that we know ourselves. (Park, 1950 cited by Goffman, 1959: 30).

Within sociology, much of the work regarding identity has focused on the intimate relationship between people's sense of self and their working lives. Work is a particularly important aspect of identity formation since it both fills a significant proportion of waking hours of individual people and constitutes a large proportion of the activity through which the structures and relationships of a society are daily re-created (Billington et al, 1998). Within Marxist theory, emphasis is placed on the negative impact of exploitative work practices within the capitalist system that

serve to alienate people from their work (Marx, 1896). However, for Du Gay (1996), work is a more positive arena, providing a sense of purpose and a source of meaning within life. People tend to introduce themselves to strangers using their working roles and this provides not only an immediate idea of what they do but of their standing within society and their likely values, attitudes and aspirations. Although the gendered division of the working and private spheres means that much of the literature focuses on the importance of work for men, work has also been shown to be crucial in shaping women's identity too (e.g. Yeandle, 1984; Hochschild, 1997; Billington et al, 1998; Benn, 1998). This is apparent in participants' accounts of their work and in particular their motivation for continuing to work after maternity leave as I show in chapter six.

### **Identity as Process and Performance**

The theory of identity as a social construct owes much to the work of Mead, who argued that the sense of self originates in a child's awareness of her separateness from others and of the possibility of viewing herself as an object towards which action can be directed (Mead cited by Meltzer, 1967). Mead described the self as both a process and the object of that process (Mead cited by Hewitt, 1984). The self as process refers to the way in which people actively work to construct their identity, adjusting to the various roles that they are assigned or adopt during their lifetime. The self as object is that upon which we work to create and maintain our sense of identity. Mead also divided the self into the inner reflective 'I' and the outer, social 'me' (Mead cited by Meltzer, 1967). The former is subjective, creative and unknowable, existing as a capacity to reflect rather than as the essence of a person (Billington et al, 1998). The latter is social, knowable and more determined by real or imagined social pressures (ibid.).

Our awareness of ourselves as separate beings in a social context depends upon our imagination through which we view ourselves from the vantage point of others (Hewitt, 1984). This leads us to adopt roles and behaviours that we think others expect of us, making us susceptible to social pressures (ibid.). However, imagination also allows us to alter, challenge or adapt the existing roles that we are expected to fill and to create new possibilities (ibid.). This dual possibility is reflected in two strands of thought that view people as either passive objects of

socialisation into existing roles, or as active participants in the construction of their own identity.

Structuralists see the individual as passively shaped by the structures of society through the process of socialisation. This involves the internalisation of roles as part of the sense of self and is the means by which society is recreated by being imported into the individual (Hewitt, 1984). It is also the means by which the existing relationships of power that infuse roles are made to seem natural and inevitable (Althusser, 1984). This passive view is challenged by constructivist theorists who argue that the self is not fixed by society but has to be actively constructed, worked at and recreated (Giddens, 1991). Although socialisation is a powerful force shaping people's sense of identity, we can also actively choose to utilise particular roles 'off the peg', we can adapt and renegotiate them (Billington et al, 1998), or we can create new roles and possibilities, although these are rare (Goffman, 1959). From this constructivist perspective, identity is the product of choice and role-playing as well as of role internalisation.

The presentation of the self through the medium of various role performances is the subject of Goffman's seminal work on identity (Goffman, 1959). He described identity as a performance in which the role that a person performs changes according to her situation and audience. For example, complete strangers performing the roles of nurse and patient can interact in physically and verbally intimate ways that would be totally unacceptable in any other context. Goffman described two ways in which we understand the roles we play. First, a role can be simply a front that we put on, a performance that is played in a specific context. In this case Goffman described the division between the front-stage where the role is performed, and the back-stage where it can be dropped. Whether a person is front-stage or back-stage depends on the presence or absence of the audience. This front-stage, back-stage division, combined with the segregation of audiences according to the role we wish them to see us in, is essential in enabling people to fulfil the common expectation described by Sartre that a person should only have one role in life. That is, a grocer should not dream of being other things, he should *be* a grocer (Sartre, 1957, cited by Goffman, 1959). This phenomenon appears later in this chapter in the common expectation that a nurse should be a nurse at all times and not simply perform the role at work. The shift of emphasis from doing, or

performing a role, to being is also of particular importance for nurses since women's social scripts are often bound up with being rather than simply doing (Billington et al, 1998). This means that working roles such as nursing are often seen as expressions of a natural feminine ability to care rather than indicating a skilled performance. As I showed in chapter four, this perspective underpins the moral imperative for nurses to care.

### **Playing a Role or Being Oneself?**

The tendency to expect that any performance should be real and exclusive points to another key aspect of identity theory, that is the desire for inner coherence and integrity and a sense of ourselves as something more than performers (Collin, 1986). This need for a more stable sense of self is also addressed by Goffman in his account of role internalisation, the process by which certain roles become something that we can believe in, a part of our sense of self (Goffman, 1959). When this occurs there may not be a front-stage or back-stage since we incorporate these roles into our behaviour wherever we are and they feel genuine (ibid.).

A core sense of the self is also achieved through the process of reflection on one's personal biography (Hewitt, 1984). Analysis of our past roles, responses and behaviours, set within the present context, provides us with a vision of who and what we are and how that person ought to behave both in the present and in the future (ibid.). Watson describes the result of these reflections as the 'cumulative sense of self' and points to the need for researchers to look at people's biographical 'careers' in order to understand their present sense of identity (Watson, 2001). This need for this biographical contextual information informed the interviews on which this study is based. However, although this process of reflection creates some coherence that binds together the roles that we perform, it is not always sufficient to counter the sense of unease that people experience when they find themselves behaving differently in different situations. This is an issue that arises later in this chapter as part of a broader discussion of the difficulties that nurses face in negotiating the conflicting demands for genuineness and behaviour that reassures and fosters communication with patients.

## **The Theory of Multiple Identities**

The tension that occurs when people find themselves behaving in contrasting ways in different circumstances centres on the belief that there is a single way of being that reflects the true self. However, there is an alternative theoretical construction of identity that allows for variations in self-presentation without the associated judgements of dishonesty or shallowness. The work of Foucault (e.g. 1970) provides the foundation for the theory of multiple identities, an approach that is based on the position that people draw on a wide range of discourses in their self-presentation. Foucault argues that discourse creates categories into which we are fitted (Watson, 2001). In this his work resonates with that of Althusser since both emphasise the way that these categories reflect and reproduce the structures of power within society (ibid.) and limit people's ability to conceive of alternative possibilities (Billington et al, 1998). However, unlike Althusser, Foucault (1970) does not see identity as simply the passive result of structural forces. Rather, he argues that people actively select particular identities that they hold when positioning themselves in any given situation. The origin of these identities, or categories, in discourse means that they are interconnected, reflecting the intertextuality of discourse, and link in to wider societal categories such as race, class and gender (Marshall, 1998). The complex, interconnected web of discourses within a society provides a rich variety of categories that contribute to the identities that people create for themselves. Leonard describes identity within this theoretical construction as a 'nexus of inter-subjectivities' rather than a collection of discrete roles (Leonard, 2003). This nexus provides a range of identities that a person can draw upon according to the situation that they are in and the aspect of themselves that they wish to present. This theoretical approach to identity informs Mullings' work on positionality which I cited in chapter two (Mullings, 1999). In this case, when Mullings emphasises one aspect of her self, such as gender, she is not being false but is drawing on a certain one of the range of identities that she holds which is appropriate to the situation she is in and the task she needs to fulfil.

The theory of multiple identities also underpins Leonard's study of identity within a healthcare setting, allowing her to explain the complexity and contradiction that characterise her transcripts of interviews with nurses and doctors (Leonard, 2003). Leonard concludes that this contradiction arises as a result of the extremely



complex social situations in which nurses and doctors find themselves. In explaining this phenomenon she draws implicitly on the work of Goffman in that she argues that nurses are frequently faced with the challenge of performing multiple, and sometimes contradictory roles, without the possibility of segregating their audiences (ibid.). The difficulties that they face are compounded by the constant shifts in their level of power or powerlessness as the audience changes in composition. For example, a nurse may be in the presence of a patient and his family when the consultant appears. She then has to decide how to position herself in terms of her identity and level of authority relative to three very different audiences, a task in which there may be no possibility of achieving success with all of those present. In this, Leonard's description of nurses' problems with self-presentation supports one of the main threads in this thesis. That is that one of the key sources of nurses' stress and dissatisfaction is the frequency with which they find themselves negotiating boundaries in situations where there are no clear answers and it is almost inevitable that they will displease someone or at best feel dishonest or inadequate.

In contrast with this negative aspect of self presentation, Leonard argues that the availability of multiple discourses also opens the doors to the possibility of playing with identity and subverting existing power structures that force nurses to behave in ways that do not accord with their own values and beliefs (ibid.). For example, she describes how one nurse chose to emphasise her 'masculine' qualities as an efficient and ruthless organiser in order to satisfy her employers at work. Although these characteristics were part of her self she was not comfortable with them constituting her entire identity and so she balanced this by emphasising her more 'feminine side' at home (ibid.). This example resonates with Watson's claim that when people experience a clash between their own values and those of the organisation within which they work, and do not have the power to resist directly, they may respond by investing more in other aspects of their identity outside of the workplace (Watson, 2001). This observation may explain the attitude of Peelo et al's nurses, cited in chapter one, who see their work as 'just a job'. It is possible that their negative experiences of nursing have led them to withdraw their investment in this aspect of their identity and to reinvest it elsewhere. For the nurses cited by Leonard, this playing with a range of subjectivities is not viewed as a problem as

each aspect is simply a part of who they consider themselves to be. However, as I show later in this chapter, many other nurses struggle to reconcile the demand to shift between apparently contradictory presentations of self with the imperative to be genuine. This can lead people to feelings of guilt and shame or of fatalism (Watson, 2001), a common phenomenon within nursing as I showed in chapter three.

In this section I have described the two main approaches to understanding identity in order to illuminate nurses' accounts of what it is to be a nurse. The theory describing identity as a social construction is of particular relevance to the substantive portion of this chapter, since it illuminates the process by which nurses negotiate the boundaries between the working and personal aspects of their sense of identity. It also brings to the fore the importance of the power structures within which the process of self is conducted. In the rest of this chapter I describe nursing as a role that its members are expected to carry into that most personal space, their sense of self, as well as beyond the physical boundaries of their workplace. As such, whether or not the person believes in their performance, there is no backstage. Since being a strong carer is an integral part of the role of 'nurse' this can create difficulties for nurses in terms of seeking support. Furthermore, the extension of the role beyond the boundaries of the workplace can place nurses in a situation where they are expected to perform multiple, conflicting roles. There is also the issue of nurses coming to believe in their performance of the role of strong nurse that, as I demonstrate, has the potential for causing serious problems when the identity of strong nurse pushes aside any possibility of accepting a more vulnerable, dependent role.

The pressure to conform to this dominant discourse of the nursing role occurs at many levels, from wider societal expectations that shape children's views of themselves, particularly as girls, and of the nurses they aspire to become. It also occurs more overtly in the power of employers and senior colleagues to enforce particular forms of behaviour and in the presence of real or imagined peer pressure. Within this context, nurses may take one of three paths. They may conform and internalise the role, which has implications for their orientation towards leaving that I consider in chapter six. Alternatively they may maintain the impression of conformity by playing the role but sustaining a sense of identity that is either only

partially invested in their work or that is entirely rooted outside of the workplace. Some may choose to resist internalising the nursing role as dictated by the dominant discourse, openly challenging and reframing or rejecting it altogether by leaving. All of these possibilities require a nurse to negotiate the boundaries between that aspect of herself that is a nurse and those that reflect other dimensions of her identity as a human being.

## **EXPERIENCES AND EXPECTATIONS OF BEING A NURSE**

### **NURSING AS AN IDENTITY**

As I argue in chapter four, within the professional discourse of commitment a person is not simply expected to work hard and prioritise their work over all else, they are expected to immerse themselves in their working role, identifying completely with its values and allowing it to shape their life. Although nurses demonstrate their commitment by extending their working hours, and by making themselves available whenever they are needed, the dominant discourse of nursing dictates that it should not be just a job or a role that a person leaves behind at the end of her shift. A nurse must identify with that role, living it inside and outside of work. Being a nurse should shape her behaviour, her attitudes and feelings and even the people with whom she chooses to socialise. The expectation of an all-encompassing commitment to nursing is not simply an ideal, it is an obligation placed upon every registered nurse and set out within the *Code of Professional Conduct* (NMC, 2002).

You must behave in a way that upholds the reputation of the professions. Behaviour that compromises this reputation may call your registration into question, even if it is not directly connected to your professional practice. (ibid.: 7.1)

You must adhere to the laws of the country in which you are practising (ibid.: 1.5)

Thus, a nurse who is deemed to have behaved in an 'inappropriate' manner outside of work, or who breaks a law with no direct bearing upon her work, may find herself facing a professional enquiry. The exact parameters of compromising behaviour are not established within *The Code*, leaving a large degree of interpretive freedom. However, from my days as a student nurse, I have vivid memories of

participating in a debate with a RCN representative who reminded us that, should we fail to pay our television licence, or be caught speeding, we would be in breach of our professional obligations. While *The Code* presents only a vague idea of what professional behaviour involves, Liz provides a more detailed picture of the kind of person a 'professional' nurse should strive to be:

- Liz            A nurse has got to have a certain type of persona. She's got to be honest, she's got to be upright, she's got to be trustworthy, and she's got to be open. She's also got to have a clean exterior. She's got to look clean and polished if we want to keep up with the professional image. She's got to be a people person.
- Alison        What do you mean by that?
- Liz            She's got to be interested in people. She's got to be *kind* to people, not be aggressive, be able to get her point of view across in a manner that's not deemed to be aggressive. She's got to have acceptable standards of behaviour. She can't go round spitting in the streets, swearing, being involved in road rage, having bad interactions with people. (Liz: 210-224)

For Liz, being a nurse involves demonstrating that she has a fundamental respect and concern for others that extends beyond her hospital department. Her position is also about appearances; in order to appear credible and trustworthy she must present an image of hygiene and good grooming consistent with her work as a health professional.

Liz's concern with presenting as a positive role model demonstrates the continued presence of a discourse that can be traced back over many years. In his study of the changing nature of the nurse/patient relationship, Armstrong cites a 1969 nursing textbook as stating that:

By being graceful, nicely turned out and looking fit and well she [the nurse] could convey a sense of good health, well-being and happiness to the patient (Pugh, 1969, paraphrased by Armstrong, 1983: 457)

Sue's memories of being a student indicate that similar ideas existed in the 1970s:

when I was a student they used to send round a circular saying 'You should not have dyed hair' and this was when punks were the thing and they were out to stop the streaked blondes and pink hair. So you thought, 'Well they can look at themselves in their hats and their blue *rinses* why should we not have pink hair anyway?' (Sue: 335-339).

The belief that nurses should present an appearance in keeping with their professional role continues today, as can be seen in the debate surrounding how many earrings a nurse should be allowed to wear in each ear (e.g. Toth and Brown, 2003; Angus, 2003).

Although maintaining an acceptable appearance and standard of behaviour both in and outside of work is part of the discourse of the good nurse, the extension of the nursing role beyond a person's working hours is not limited to maintaining such standards. Nurses are also expected to make their skills and knowledge available to anyone who might need them whether they are friends and family or complete strangers. The range of services that participants offer to others range from advice given to friends and family, through 'hands on care' provided to sick parents, to emergency first aid given to strangers in the street. Barbara demonstrates the commonly held perception that a nurse should be available at any time and is never really off duty:

if there's a family member ill, my sister will phone me and say, 'This has happened' and I try and use the knowledge I've got. I don't say 'Oh I'm off ...' well I might as a joke say 'Oh I'm off duty' but I certainly don't mean it. (Barbara: 490-494)

Within the dominant discourse, a nurse is expected to be a nurse at all times and with all people.

The idea that nursing is not simply a role that one plays, but is a part of a person's identity, extending into all aspects of her life, is a strong theme with participants' accounts. While some describe nursing as a part of who they are (Heather: 148; Elizabeth: 406-410; Anne: 846-850; Robert: 383-395; Valerie: 612), prior to leaving, Lesley's entire identity was bound up with being a nurse:

For me I suppose that's just what my identity was (laughs). It was like 'Lesley just always knows what to do', and that always happened in my friendships and things. People would always be phoning up saying 'What should I do about this?', physical things and psychological things. So it was just always that was who you were, that's your identity. And not only was Lesley a nurse, but Lesley was a nurse who had gone all over Europe presenting at conferences, and *then* became a sort of 'Super Nurse' person. A lot of people just thought it was really *fascinating*. And also because you had these *great relationships* with doctors and doctors were your *friends*., they weren't just kindae people that you *knew*. They were people that you socialised with, and I suppose there must have been

some kind of kudos about that and it was just my *life*. (Lesley: 545-562)

For Lesley, nursing shaped her whole life, in and out of work, and provided her with an identity that carried some status among her friends and acquaintances. Her experience of total involvement is echoed by Claire who speaks of nursing as 'all encompassing in your life' (Claire: 651). I asked Kate to what extent nursing is a part of who she is:

Kate	Probably everything (...) everything, I mean my life, because I went to school, I came to nursing, I'm now a nurse, my husband's a nurse ...
Alison	You're enmeshed in it all really?
Kate	Mm, I can't get out (laughs). (Kate: 675-679)

For Kate and Lesley, nursing became the framework for their lives. For Christine, nursing has become such an integral part of who she is, that when she took maternity leave she felt that she had lost her identity:

I knew it was part of my life but I didn't realise how much an integral part it had felt, [how much] of my life was *being* a nurse, and having my little position as a nurse. I don't know. It was really quite odd. (Christine: 108-111)

For these three people, a commitment to nursing has literally given shape to their sense of self and their place in the world. While Lesley made the decision to leave nursing, both Kate and Christine struggle to imagine not being nurses. This is an experience that is shared by Karen (756-759), Mary (137-146), Claire (537-549), Barbara (859), Eileen (418-419), Judy (694-699) and Robert (619-620).

Many participants describe how becoming a nurse changed their whole way of thinking and being with others. Some speak of growing up in nursing (e.g. Heather: 127; Judy: 548-553), and most embarked upon training at the impressionable age of sixteen or seventeen. Maria describes how her tutors moulded and sculpted their students (276-325), while Christine says of her need to be in control:

I'm sure it's all from [the] indoctrination of nursing, because I never used to be that sort of person. I was always haphazard and spontaneous (Christine: 285-287).

However, the changes that participants describe in themselves are not all the product of deliberate indoctrination or socialisation. Nursing involves contact with the extreme experiences of life, death and suffering, often in the absence of any

support, and several participants comment that exposure to such extremes, at a time when they were barely out of childhood, forced them to grow up extremely quickly (Anne: 417; Kate: 98-113; Frances: 275-293; Liz: 68-71; Emma: 123-149).

For some participants, becoming a nurse has increased their self-confidence, particularly in relating to other people (Eileen: 531-539; Jean: 475-481; Margaret: 142-147; Mark: 296-300). For some, like Lesley, being a nurse is something of which they are obviously proud.<sup>48</sup> However, others appear to have a low sense of self esteem associated with their work. For example, despite possessing sophisticated communication and organisational skills that would be of great value to employers in a variety of settings, Kate has come to identify so strongly with nursing that she believes that she is not capable of anything else.

I will be a nurse because I can't do anything else and I don't really want to do anything else. If I was a great painter or I could make pots I would probably set up on my own and do that but I'm really not good at anything else so that's why I'm a nurse. (Kate: 628-632)

This extract demonstrates Foucault's argument that a powerful discourse sets limits on the possibilities that an individual can conceive of and is significant on two key levels. First, in Kate's apparent low valuation of both herself and nursing: she is a nurse because she can't do anything else. Her apparent low self esteem and lack of confidence echo the way in which Lindsay, Elizabeth, Jane and Gemma denigrate the importance of their work in chapter three. This provides a stark contrast with Lesley's description of her work as a source of 'kudos' (562). Second, Kate highlights the perception among some nurses that, since they have no transferable skills, they have no other career options. While Kate is lucky in that she enjoys her work, others are less fortunate, finding themselves in a situation where to continue nursing is as unthinkable as leaving. This is a phenomenon that I return to in chapter six.

In addition to its impact upon people's self esteem, nursing also shapes the way in which they respond to others in more specific ways. For some, becoming a nurse has increased their sympathy, patience and willingness to listen to others (Barbara: 475-486; Karen 563-575; Jane: 383-422), while others find that their exposure to real

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<sup>48</sup> Although Lesley is no longer practicing and does not intend to return to nursing, she still sees herself as a nurse. I address the continuation of this identity after a person has left nursing in chapter six.

suffering leaves them with less sympathy for the minor complaints of family and friends (Kate: 682-694; Emma: 294-302; Anne: 427-438). For Jane, Sue, and Frances, contact with serious illness and injury have contributed to a constant background fear for the health and safety of themselves and their loved ones that influences their relationships. While Sue (242-243) and Frances (300-301) worry that arguments with loved ones might trigger a heart attack, Jane nags her boyfriend to stop smoking (Jane: 399-405). Frances also describes 'an unhealthy preoccupation with "what if"' (Frances: 294), demonstrating a concern for herself as well as her loved ones:

One of the sisters I worked with once was about to leave the ward, she said 'Now, I'm going to go to the loo. Now I only live up the road but I have seen too may traumatic bladder injuries to drive with a full bladder'.<sup>49</sup> So [now] I go to the loo before I go out in the car and *ridiculous* things like that that I do. (Frances: 295-299)

These participants see the world through the eyes of a nurse, living with a background anxiety created by experiences that have shown them the fragility of life. Their fears impinge upon their relationships and day-to-day activities in ways that, for other people, might be labelled as neuroses.

For some participants the extent to which nursing has become a part of their day to day way of being means that they are identifiable as nurses, to complete strangers in situations that give no clue as to their working lives. For example, Gemma comments that strangers in the street often come to her for help (Gemma: 485-494), while complete strangers have specifically identified Eileen as a nurse.

strangely enough people will often say, 'Are you a nurse?', and I think 'Have I got it tattooed on my head or something?' (Eileen: 477)

I too have had this experience when a tradesman came to my house. As we chatted over a coffee, he said 'You're a nurse aren't you?'. When I asked how he knew he said that from the minute he arrived I had tried to make him feel at ease and that he has seen this kind of behaviour in many other clients who are nurses. I was completely unaware of behaving in this way, but it seems that this important nursing skill has crossed over into the way I behave outside of work. Emma has

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<sup>49</sup> This nurse is referring to the fact that a person who sustains pelvic injuries in a car crash is more likely to damage their bladder if it is full, and therefore distended, than if it is empty.



also shared this experience, but in her case the aspect of her nursing identity that crossed over into her personal life was a concern with hygiene and order.

- Emma But people who don't know me, when they start to talk to me and ask me what I do, and I say 'I'm a nurse', they're not surprised and I don't know what it is. In fact I can remember going on a holiday when I was sixteen or seventeen, people were asking me what I was going to do and I said I wanted to be a nurse. They said 'I knew you were going to say that, you've just got that *scrubbed* look about you' was what he said (laughter). I don't think it does but people are often not surprised to learn that I am a nurse.
- Alison Could you guess what it might be about you that they spot?
- Emma I wonder is it the sort of organisation, the *in charge* sort of thing as a ward sister? (Emma: 315-325)

Emma's translation of being a ward sister into a general impression of being 'in charge' outside of her work is shared by Christine:

it was a big standing joke at home [they would say] 'God, sometimes Christine you should leave your nursing at work and not be bringing it home'. Because as soon as anyone starts, or if I'm moaning about cleanliness its like, 'Here she goes, she'll give us some figures next about infection control or food hygiene or something. So I think it has definitely has made me more ritualistic and more controlling, and you almost run [your home] like a ward, at times. (Christine: 301-309)

For Christine, carrying her nursing identity home creates some tension with her family who would apparently prefer a more relaxed atmosphere. Her comments, and those cited above, indicate how the extension of a nursing identity beyond the working context can create problems in the relationships that nurses have with their friends and family. This is a phenomenon that I return to at the end of this chapter.

So far I have described a dominant discourse in which a commitment to nursing is expressed in the way that nurses identify with their working role, transforming it from a part to be played during working hours, to a way of being in the world. The question now arises: What does it mean to be a nurse in terms of the day to day expectations that nurses attempt to fulfil? In the following section I describe a powerful discourse within nursing that makes intense physical and emotional demands upon its members, expecting them to sacrifice their own needs in order to meet those of their patients. According to this discourse, a good nurse expresses

her commitment by identifying herself with a role that has no room for human weakness, and demands boundless levels of endurance and self-sacrifice.

## **EXPECTATIONS OF THE GOOD NURSE**

### **A Good Nurse Prioritises the Needs of Her Patients**

One of the most important demands made upon a nurse is that she should be prepared to prioritise the needs of her patients above all else. Christine makes the connection between commitment and the prioritising of patients' needs explicit:

As for my colleagues, I know they definitely appreciate my level of commitment and the level where I'm working at. They know no matter how high up I've gone up the ladder, that my priorities have never changed from being patient focused and [they recognise] my commitment to care and maintaining standards (Christine: 395-399)

Emma shares Christine's emphasis on the patient as a priority:

To me, a good nurse is somebody who, to use the modern day phrase, they're patient focused,<sup>50</sup> they always put their patients first (Emma: 251-261).

For Liz, prioritising patients' needs requires a total commitment, to the extent that when a nurse is at work she exists solely for the benefit of her patients.

The good nurse [is] that I try to totally be there for the patient, to be everything to that patient that I would want, for a member of my family, for myself (Liz: 117-118)

Liz's understanding of the 'good nurse' suggests that it is not enough simply to work hard in order to provide a high standard of care: a nurse must put herself into her work, setting aside all personal considerations. This total focus on the needs of the patient is also seen in Elizabeth's response to a period when the pressures of work became too much and she began to burn out:

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<sup>50</sup> It is important to distinguish between participants' use of the phrase 'patient focused care', and its use by managers and policy makers. Buchan describes 'patient focused care' as a label attached to new methods of organising care delivery that emphasises 'multi-skilled care teams'. The aim of 'patient focused care' in this sense is to reduce labour and administrative costs through changes in skill mix, working patterns and staffing levels (Buchan, 2000a). While Emma's use of the term reflects a nursing, more than a managerial meaning, her reference to 'a modern day phrase' indicates that, as a manager, she has encountered this alternative meaning.

I thought 'If I can't give that I should *not* be in nursing. If I'm losing my ability to care I should not be in nursing'. (Elizabeth: 119-121)

Despite Elizabeth's concerns about her ability to give, and the toll that giving so much took on her health, she continued to nurse until a change in her husband's job allowed her to move to a new post in another city. It seems as if Elizabeth was unable either to reduce her level of giving, or to leave a post that was damaging her own health.

In a paper written for the *Nursing Times*, Zöe Lloyd, a district nurse, describes how her attempts to keep giving to her patients whilst neglecting her own needs led to a nervous breakdown and eight months of sick leave. The pressure to continue without asking for help came from her belief that 'It's only the weak links who can't cope' (Lloyd, 2002: 24), and was intensified by patients' comments indicating their reliance on her (ibid.). These examples suggest that the demands arising from a commitment to nursing are almost without boundaries. A nurse is expected to set aside any consideration of her own needs in order to meet those of her patients. She must give as much as necessary in order to reach the required standard, even if this means damaging her own health and relationships in the process.

### **A Good Nurse Accepts that Hard Work is Part of the Job**

In order to achieve a high standard of care, nurses are expected to work phenomenally hard, demonstrating considerable powers of physical and emotional strength and endurance. Nightingale particularly stressed this aspect of nursing in her attempts to ensure that only the most suitable women were accepted for training.

What was required ... was an appreciation of the fact that nursing was hard work in which one might become a 'worn and sorely-harrassed woman'. (Nightingale cited by Rafferty, 1996: 30)

Nursing continues to be seen, by definition, as hard work, and a willingness to accept this is a part of the commitment that a person takes on when they become a nurse. As Mark explains:

I knew nursing would be challenging, I knew it would be hard work and maybe I'm just not afraid of hard work (Mark: 157-168)

Lesley shares Mark's perspective, stating that 'Hard work and demands are a part of nursing' (Lesley: 632). In participants' reflections on what makes a good nurse,

the importance of pulling one's weight as part of a team is a recurring theme. As I showed in chapter four, Maria encountered this particular expectation at an early stage in her career when she struggled to complete 'her' work before the end of a shift.

a lot of times you wouldn't get your lunch break, you'd get maybe a breakfast break which was fifteen minutes, you wouldn't get your lunch break and you'd be guaranteed off, rather than three o'clock in the afternoon you'd be off at four...

... no wonder I was there 'til five o'clock. And in the first week I was due eight hours back, a whole shift back with eight hours, like 'This is awful' and everybody just didn't seem to even want to help you. (Maria: 77-80, 86-89)

Maria's colleagues seem to have made no concessions to her lack of experience, leaving her to get on with 'her share' regardless of how long it took. Christine also reflects this belief that a nurse should complete her own work and not pass unfinished work on to the next shift.

I'm very aware of nobody picks up my job when I'm not there so if things are half done, then they've got to be able to be left half done until tomorrow, and sometimes that's not possible. (Christine: 691-693)

Although at times she does leave work for the charge nurses to complete, Christine describes this as 'offloading' (694), a rather pejorative term that suggests she does not see this behaviour as being acceptable. Christine's attitude, and Maria's experiences, can be understood with reference to the work of Clarke, who found that nurses place great emphasis on pulling their weight and taking their 'fair' share of the workload (Clarke, 1978). Melia also noted the emphasis on speed and pulling one's weight, describing these as unwritten rules that are enforced through moral pressures and social controls, leading to feelings of guilt or fear of poor ward reports among student nurses (Melia, 1987). For both Maria and Christine, the imperative seems to be to continue working until all of 'their' tasks have been completed, regardless of the time it takes to achieve this. In Christine's case, combining motherhood and nursing requires her to complete the excess work at home.

### **A Good Nurse is Prepared to Work Through Her Breaks**

In her experience of working through breaks, Maria is not unusual. Several participants speak of the 'need' to work through breaks and to stay on at the end of a shift in order to maintain the service. Mark attributes this to the intensity of the workload and the shortage of staff available to cover breaks (Mark: 660-674). As district nurses, Barbara and Jean both describe regularly missing breaks because of the level of the demands made upon them (Barbara: 412-415; Jean: 223-224) and Barbara doesn't see herself as having any choice in the matter:

There have been times when I've given far more *time* than I'm actually *employed* to give. You work through lunch and you don't finish 'til an hour after you're meant to finish. But then you've no option so whether you want to do that is irrelevant (...) almost, at the time. (Barbara:411-415)

My own experience as a staff nurse was of a situation in which our employers had built nurses' acceptance of the need to work whatever hours are necessary into the day to day running of the wards. Cover for qualified night nurses' breaks was not usually provided: instead we were expected to sit in the patients' day room within calling distance, while the auxiliaries kept an eye on the patients. On busy nights this meant that we worked through from ten at night until seven in the morning with no break at all. When we complained about losing coffee breaks during day shifts, our charge nurse reminded us that our only entitlement was to half an hour for lunch and that the fifteen-minute morning break was discretionary.

As with overtime, the phenomenon of nurses working through breaks is not always a result of extreme workloads or pressure from seniors. Some participants seem to have a more general difficulty in detaching themselves from their work in order to take breaks or go home. As Christine indicates, it can be difficult for nurses to say no to a patient even when it is possible to hand over to somebody else or to leave an aspect of care until later

I think as a nurse you find it very hard when you have a person physically in front of there who's requiring all these needs from you, to kind of walk away and say 'Sorry, I can't deal with this today, I'll deal with it tomorrow', because its people. (Christine: 698-701)

The dilemma facing a nurse who is about to go off duty fifteen minutes late when a patient asks her for a commode is used by Edgar in an exploration of the moral tradition of nursing (Edgar, 1993). The problem is framed within the broader

expectation of self-sacrifice and the likelihood that a nurse who refused this request would be branded as selfish and therefore a bad nurse. On the other hand, staying to carry out the request could lead to a sequence of other requests. On a busy day, a nurse has to hand over some work to another nurse in order to get away at all.

As I showed in chapter four, working extra hours is one way in which nurses are able to demonstrate their commitment. This symbolic connection between commitment and working through breaks or staying late leaves nurses in a vulnerable position in relation to their managers who, as I have shown, can exploit their willingness, building it into the daily routine and so imposing it upon the whole team.

### **A Good Nurse is Never Sick**

In a recent survey, the Healthcare Commission reported that ward based nurses have a higher sickness absence rate than any other group of public service employees, with an average of 16.8 days off per annum as opposed to 11.3 days across all other surveyed groups (Healthcare Commission, 2005). This high level of absence occurs despite a tendency among nurses to work even when they are sick (Mackay, 1989; Carlowe, 2000; Plant and Coombes, 2003). Christine's experience is of a working culture in which sickness is not acceptable among nurses, reflecting the discourse of nurses as strong people who should be able to cope, sharing the load and pulling their weight under all circumstances.

I just think that nursing doesn't allow you to be off. We're not compassionate to people who are off sick particularly. (Christine: 728-730)

However, nurses' attitudes towards taking sick leave seem to be more complex than Christine's statement implies. For example, Barbara (591-600), Jane (998-1035), Anne (167-170) and Christine (725-730) all reject the idea that nurses should work when they are unwell, but admit that when they are ill they feel guilty about letting their colleagues down and go to work if they are able to. Liz demonstrates the complexity of nurses' attitudes towards sick leave:

At the end of the day you need to be 100% for your patients so I wouldn't applaud or advocate people coming in when they're sick or staying on when they're absolutely exhausted. And there has to be a cut off point, and I think that nurses have come to realise 'If we just

keep doing it then people will let us do it and we'll never get more staff' so ultimately we're not doing anybody any favours and at the end of the day, your responsibility is to yourself. (Liz: 544-550)

For Liz, working when she is sick opens the doors to exploitation in a similar manner to that seen above in relation to working through breaks. However, when talking about herself she seems to have a completely different perspective:

To have a sick day on my record would be the worst thing that could happen. I've come in purposely just so as not to get a sick day on my record which is silly. And there's been times, particularly when I've been a charge nurse and you've been exhausted, but the ward's been going through a bad time and you've wanted to be seen to be there for everybody else, almost to get everybody else through that bad time. (Liz: 554-560)

In her willingness to work when sick, Liz shares Kate's emphasis on team solidarity seen in chapter four. Her general belief that nurses should not work when they are unwell seems to be more grounded in their need to be fit to care for their patients than their right to care for themselves. Although she qualifies this position by stating that one's ultimate responsibility is to oneself, she does not seem to apply this expectation of self-care to herself, emphasising instead the importance of being seen to be strong. I asked her 'What is so bad about having a sick day?'

Nothing, nothing. But it's just ... I quite like ... I've never had a sick day. And just your upbringing. If you can drag yourself in to work you do. And the feeling of letting other people down and being perceived as being a weak person. And also this foreboding dread that 'God, at least, if ever I am really ill then people will know that I'm really ill. (Liz: 562-568)

Liz's desire to be strong seems to reflect not only a feeling that she should be there to support her colleagues and share the load, but also a fear that if she takes time off, they will think she is trying to shirk some of that load. This fear suggests that Liz does not expect other nurses to trust her, a fear that is well founded according to Mackay who described a widespread scepticism about absenteeism among nurses (Mackay, 1989). Alternatively Liz's fear may reflect a polarisation of the roles of strong nurse and dependant patient that I return to later in this chapter.

While conducting the interviews for this study, I had a more direct insight into the implications for nurses who attempt to continue working when they are unwell. Ruth postponed her interview due to illness and was on sick leave for several months. When she returned to work we arranged a new appointment but after a

few minutes it became apparent that she was struggling to answer my questions and we ended the interview. She explained that she had been receiving psychiatric care over the previous months. I wondered how she was managing to cope with her demanding job when she had found my initial request for a quick précis of her career too much to cope with. I was reminded of my own struggle to make sense of clients' questions when I returned to work after maternity leave, and how I tried to appear normal until the strain proved too much and I was sent home to start what subsequently became a prolonged period of sick leave.

The examples cited above all relate to individuals' attitudes towards taking sick leave. However, other participants speak of their direct experiences of the widespread expectation that good nurses do not become sick. Mary shares the belief that she should not let her team down and has, on occasion, been told to go home by colleagues who have noticed her condition. However, she also describes how she was put through the disciplinary procedure as a result of a chronic illness that led to several sickness absences and even hospitalisation.<sup>51</sup>

- |        |   |
|--------|---|
| Mary   | There was one time when I <i>wasn't</i> well at all and I went into work when I knew I shouldn't have, but it was a priority to get into my work, although I knew I wasn't doing my best.   |
| Mary   | <p>Alison      What was it that made you go in?</p> <p>I thought I was going to get into trouble and that I was letting my colleagues down as well, again. Because I'd been off and I thought 'You need to go in Mary' and everybody was saying 'Mary, for goodness sake you look <i>terrible</i>, you sound terrible' and I went 'No, I'm fine, I'm fine, I'm fine'. But there was two reasons; I felt that I'd let my colleagues down because I'd been off sick a lot. Apart from [that, it was because of] the nurse manager saying 'Yeah, Mary, you're going to have to have a look at this'.</p> |
| Alison | You said that you were worried about getting into trouble. Have you ever got into trouble for ...?  |
| Mary   | Oh I have been. Once there was an investigation into my sick time but I just got a reprimand for four months. Saying 'We're going to be looking over your sickness  |

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<sup>51</sup> There is always the possibility that Mary has either misunderstood the nature of the proceedings or forgotten the details. However, during the interview I explicitly double-checked her reference to disciplinary proceedings on more than one occasion. By chance, when I interviewed a senior nurse from the same ward she independently referred to the use of disciplinary proceedings against Mary and described feeling horrified at the unfairness of this action.



time' but at that time my health was better, much better.  
 Alison So you got a reprimand for being sick?  
 Mary Yeah (Mary: 430-456)

Throughout her account of the disciplinary proceedings and her fears of being told that she could no longer nurse, Mary shows no indication that she thinks it strange that disciplinary proceedings should be instituted for illness. She is simply relieved that she received a four-month reprimand on her record rather than losing her job.

The physical sacrifices that some nurses are expected to make for their work are far greater than the forgoing of a break or working with a sore throat or cold. Although Lindsay's problems arose because she was pregnant rather than sick, she experienced the same pressure to continue working at her normal level, despite the limitations that her pregnancy created, and the danger to her own health and that of her child.

When I was pregnant with my *first* son, I was working full time and I was doing every second weekend 'on call', and I was doing two 'on calls' through the week as well. On one occasion I was working from half past one in the afternoon, lunchtime, to two in the morning, and coming back into work for eight in the morning. And I did that *twice* during the week and it involved doing an 'on-call' at the weekend. I was thirty-three weeks pregnant at the time. My GP said I was to stop doing calls. I then went to my nurse manager and said 'My GP has said I am to stop doing 'on calls'. I had only planned to work another couple of weeks. And she went 'Well there's nothing I can do about that. You will have to ask each individual member of staff to swap and do your calls for you'. (Lindsay: 173-185)

In this instance, the welfare of both Lindsay and her unborn child seems to have been treated as secondary to the needs of the service. From her account of the incident it appears that, as a nurse, she was not accorded the same rights and level of care that nurses expect to offer their patients. Despite her condition, she was expected to remain strong and continue with her work regardless. Her role was that of nurse not patient, and her pregnancy was treated as 'her problem', one that she should address herself in order to ensure that it did not interfere with the service that she and her colleagues provided.

Despite the belief of most of these nurses, that a sick person should not be expected to go to work, they describe a situation in which nurses feel compelled to do so either because of direct coercion from colleagues and managers, or because of their

personal feelings of guilt. These feelings suggest the internalisation of a rule that good nurses never take sick leave.

### **A Good Nurse Does Not Make Mistakes**

The physical demands that these expectations make upon individual nurses are magnified by a discourse of perfection in which there is no room for failure. In a letter to the *Nursing Standard*, a nurse who was dismissed for making a mistake, and who subsequently won an appeal against the decision, wryly asks 'Have you ever made a mistake? No, impossible. You are a nurse, a professional' (Anonymous Nurse, 2000b: 22). In other fields of work there is a trend towards the perception that mistakes provide the opportunity for learning, and that they often reflect the weaknesses in a system rather than the failure of individuals (Argyris and Schön, 1978; Leadbeater, 2000). However, Hancock<sup>52</sup> describes nursing as having 'a culture of blame' leading to a situation in which nurses are often disciplined more harshly than doctors for similar offences (*Nursing Standard*, 2000b: 7). While Meadows et al describe this culture as changing towards a more positive emphasis on learning from mistakes (Meadows et al, 2000), such changes occur slowly, and many nurses are still treated harshly for their mistakes and omissions and a climate of fear persists (*Nursing Times*, 2003b). For example, Mark describes how, on a particularly busy shift, he placed a new delivery of controlled drugs (CDs) directly into the double locked cabinet, to keep them safe until such time as he could return to record the delivery properly with another qualified nurse.<sup>53</sup> In his eyes, it was more important to ensure the safety of patients than to complete the required paperwork. However, a more senior nurse arriving for the next shift castigated him for his omission, and made him complete an incident report. Regardless of his plea that the ward had been too busy for staff to even take breaks, this nurse would accept no

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<sup>52</sup> Christine Hancock made these comments in her capacity as RCN General Secretary at that time.

<sup>53</sup> Controlled drugs such as morphine are subject to strict legal requirements and must be kept in a locked cabinet within another locked cupboard. New orders of phials or tablets are counted and recorded in a dedicated book. Each time a dose is administered, those remaining are counted again, and a check of the entire CD stock is also carried out once during each shift. Two qualified nurses must perform every check, a requirement that often causes difficulties when there are only two qualified nurses on a shift.

excuses and showed no understanding of the predicament in which Mark had found himself (Mark: 660-674).

As a junior staff nurse I found a similar lack of support from colleagues when I was involved in a mistake over the administration of morphine via a syringe driver.<sup>54</sup> The doctor who set up the pump had been awake for thirty-six hours and made a mistake in setting the rate of flow. My responsibility was to counter check the settings, and then to monitor the volume that had been administered every half hour. However, I too was exhausted and did not notice her error. Owing to the heavy workload and inadequate staffing levels, I also lost track of the time and returned after an hour to an empty pump. Fortunately the morphine had been of a low concentration and the patient was sleepy but not harmed. However, the nurse in charge of the night shift that followed was furious, reminding me loudly, in front of all the other staff, that the patient concerned could have died. Her attack was nothing compared to my own sense of horror and guilt at what I had done. In contrast to our reactions as nurses, the consultant took me to one side to ask how I was, and to reassure me that the error was largely a product of the unsafe situation on the ward, which he intended to address.

While these two examples show how harsh nurses can be to those who make mistakes, Elizabeth's experience demonstrates that nurses can be equally hard on themselves. She too made a mistake with a morphine syringe driver and was lucky that the patient was unharmed. In contrast to my situation, Elizabeth's senior nurse was very supportive, but Elizabeth condemned herself saying 'I felt I should never nurse again' (Elizabeth: 221-224). Her self-condemnation is in stark contrast with her acceptance that, in general, mistakes happen under pressure (Elizabeth: 199-204). There seems to be a similar attitude here to that described in relation to the taking of sick leave, that is, in both instances we see nurses who apply much harsher standards to themselves than to their colleagues. It seems that some nurses are prepared to challenge the dominant discourse of the perfect nurse on behalf of their colleagues whilst refusing to make any concessions for themselves.

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<sup>54</sup> A syringe driver is a piece of equipment that depresses the plunger of a syringe at a controlled rate, administering the contents over a measured period of time. It is frequently used to administer morphine as a continuous low dose to people in the terminal stages of an illness. This provides better pain control, and is less distressing, than periodic injections.

In the quotation that heads this thesis, Mrs Mollett writes that a nurse must

be content to bear unmerited blame without murmuring, to be scolded for mistakes that were made in all good faith. (Mollett, 1888 cited by Jolley and Brykczynska, 1993: 14).

Rafferty refers to a similar attitude in which the acceptance of unfair criticism was seen as part of the test of a nurse's character and formed a part of her training (Rafferty, 1996). Despite the acceptance by some participants that mistakes will happen, particularly under pressure, expectations of the perfect nurse who can carry any burden without slipping appear to have survived into the twenty-first century. While in other jobs, a mistake might mean the loss of a contract or an increased workload, nurses fear to make mistakes that will lead to serious injury or the death of a patient. Against this background of impossible expectations and high stakes, the fear of harming others is a constant presence for many nurses. This provides an additional motivation to work hard in order to ensure that no aspect of the work is left undone and that it is completed to a high standard.

### **A Good Nurse Always Appears Calm and in Control**

In addition to the widespread expectation that nurses need to be physically strong in order to fulfil their commitment to nursing, there is a parallel expectation that a good nurse is emotionally strong and self disciplined enough to be calm and in control under all circumstances. Barbara uses the metaphor of the nurse as a swan, appearing to glide calmly and effortlessly through the water while paddling furiously beneath the surface (Barbara: 238-240). This image fits many participants' descriptions of good nursing (Gemma: 225-227; Maria: 449-453; Margaret: 178-182; Elizabeth: 194-201; Barbara: 241-246; Eileen: 161-167) and the broad expectation seems to be that a good nurse controls, or covers up, any negative feelings she may have. For example, during a period of conflict in her department between the nursing staff and their new manager, Eileen claims:

The relationship with the patients didn't change. I mean the patients weren't aware there was all this upheaval going on, which I thought was quite good from our part, that we were still able to go out there and carry on. So long as you got back into the duty room you could sort of feel miserable but no, the dynamics with the patients didn't change. (Eileen: 257-263)

For Eileen, the measure of her success is that the patients had no idea that their nurses were so unhappy.

In chapter four I argued that the permeability of the barrier between work and a nurse's private life is unidirectional. A similar situation exists in relation to the control of feelings relating to a nurse's life outside of work. Although nurses often carry feelings generated at work home with them, participants' accounts suggest that nurses are expected to ensure that feelings relating to their personal lives do not encroach upon their working responsibilities. For example, Mary speaks of how she attempted to maintain her 'normal' demeanour at work during a period when her sister was experiencing domestic abuse (Mary: 243-253). Mark explains why he attempted to achieve an appearance of normality during a period of particularly severe family problems:

It's not appropriate to be nursing someone who is terminally ill, for them to say to you 'Oh, you don't look very happy today.' and for you to turn round and say 'well actually my sister's just tried to commit suicide.' You just don't go there (laughs). You almost want to say to them, 'Well, I'm worse off than you today.' (Mark: 525-533)

Mark believes that taking sick leave for psychological reasons is acceptable, and even necessary if a nurse is unable to operate. However, a nurse who takes sick leave under these circumstances may face criticism from her colleagues and seniors (Barbara: 609-620; Christine: 729-730). For Mary, her personal problems were something she had to leave behind at the door of the ward; taking time off, or talking to her seniors, did not seem to be possible options.

The door of the workplace is a key image that appears in several interviews, apparently symbolising the boundary between the private and working lives of nurses, between one performance and another. Participants speak of the importance of leaving their worries on the appropriate side of the door as they step across the threshold between their two worlds, work and home. Although the door metaphor suggests an immediate transition from one role to another, participants also speak of the importance of a period of time alone after a shift during which they have the chance to reflect and put their thoughts in order before fully shifting into the roles they play outside of work. Both Judy and Barbara use the walk home at the end of a shift to talk to themselves so that once they reach their homes they can switch off from work completely (Judy: 644-656; Barbara: 661-

669). This period is so important to Judy that she rejects any offers of a lift home by colleagues. Karen has a long drive home, commenting that 'normally I manage to leave my problems in the car' (Karen: 289-293). Both Judy and Liz enjoy swimming after work, using that time to reflect on work issues (Judy: 648-651; Liz: 288-291).

These accounts of managing feelings all relate to the need for time and space for adjustment after a shift. In Goffman's terms this is time spent 'backstage', preparing for the next role. However, participants have greater problems in compartmentalising their feelings and remaining in control when shifting from one situation to another during a shift where there is no backstage. They describe the importance of compartmentalising the feelings generated by patients so that each one is offered the same calm service.

you have to be able to *leave* that house and go to the next patient and not take that problem, because it's not fair to that person. So even if you leave somebody who's very young and who's dying, and it's *absolutely traumatic*, you still have to be able to get back in your car to go and visit a patient *knowing* they'll chew your ear off for being a bit late. You're just giving [them] a bit of skin care or something, but you just have to be able to accept that. (Barbara: 462-469)

For the district nurses, the car journey between each visit provides some backstage time during a shift and is an essential respite that enables them to fulfil this expectation. Barbara describes how she manages to cope with subsequent visits after particularly difficult episodes:

You'll drive along and half the time you're on automatic pilot because you're going over in your head what's been happening and all the emotion. But then you get to the next house, you ring the doorbell and just this face comes on of 'Good morning', but once you've left the house and got back in the car then it all keeps coming back. It's always these short journeys in the car where you literally go through whatever's just happened that's been upsetting. And then, hopefully, by lunchtime when you finally find a colleague, you might speak with them. (Barbara: 642-654)

The importance of this time to the district nurses throws into relief the contrasting position of hospital nurses who often need to shift into a new performance very rapidly with little or no opportunity for privacy when their situation becomes too much to cope with. Both Judy and Barbara refer to their time as hospital nurses when they used the sluice as a refuge (Judy: 215; Barbara: 634-636), an experience that I have shared too. As a student, I remember the first time I was involved in

performing the last offices.<sup>55</sup> When we had finished, I walked through the door of the deceased person's room to be faced by another patient's daughter who wanted to ask about her mother's progress. I struggled to smile and talk normally with her for a few minutes before escaping to the sluice under the pretext of arranging the flowers she had brought. Very early in my career I learned that it would not have been acceptable to let this woman know what I had been doing or how I felt about it.

Heather's account of a very different experience she had as a student also illustrates the point. A patient who had been on the ward for a long time, and who had been a general favourite, died. The other four nurses on duty went off together into another room to cry together and Heather was left with the remaining twenty-four patients, wondering what to do for them. She was aware that several had the same diagnosis as the woman who had just died, but were 'not so far along the path', a situation that created a great deal of fear for them. (Heather: 95-100). I asked Heather if this is a common reaction to death among nurses and she replied that this withdrawal for mutual support is unusual in her experience (Heather: 105). Heather was critical of these nurses for putting their own need to express their grief before the needs of their remaining patients, taking the position that, while it is important to acknowledge your own feelings and seek support, the needs of the patient have to come first (Heather: 101-102).

The reasons that participants offer for this expectation of emotional self control and perpetual calmness reflect the dual purpose of protecting both nurses and patients within a situation that often has the potential to become chaotic and frightening. As the co-ordinating force at the heart of patient care, nurses find themselves in extremely complex and demanding situations, juggling several activities at any one time. Although time management skills are essential, a nurse can never entirely predict her workload. She must be able to juggle her own work whilst responding to the unpredictable and simultaneous demands of patients, doctors, relatives and an enormous range of other health care professionals and support staff. The most organised nurse will, at times, find that her plans are overtaken by events. All of

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<sup>55</sup> The last offices are the rites performed in order to prepare a body for burial. When a person dies in hospital and their relatives wish to see the body, the nurses wash and prepare it to make this experience easier for them. Before the body is taken to the mortuary the nurses prepare the body again, wrapping it in a shroud and attaching an identity label.

this occurs in what can be a very noisy and busy public space . To add to the pressure, nurses face the extremes of life on a daily basis. They may find themselves moving between the joy of achievement, when a patient who has had a stroke walks for the first time (Karen: 808-812), to the sorrow of another patient's death (Mark: 46-48), within a matter of minutes. Gemma describes the need to learn how to maintain a calm front in vivid terms:

- Gemma      I think what you learn as a nurse is how to do it calmly and not show somebody you're just about on the ceiling and you need scraped off it. Whereas as a junior nurse then everybody would have known that I was absolutely stressed out my head because I would have been hyper I and I was trying to do everything, whereas now I would say I'm much calmer. But whether that's because there are so many other things going on, if I got stressed about it I would end up in a loony bin, or whether it's because you become more experienced, that you learn to cope with things better, I don't know.
- Alison      And do you feel calmer on the inside or are you just trying to cover it up?
- Gemma      No you're just the same on the inside as wooah (waving hands), but you just look calm, just stay calm. (Gemma: 460-475)

Part of Gemma's need, as a student, to learn how to remain calm seem to be about personal survival and retaining a degree of control in what can be an extremely stressful and chaotic setting. Both her ability to carry out her work and her sanity depended upon developing skills in emotional self-control. In this she supports Froggatt's observation that, for nurses, emotions are dangerous forces that pose the constant threat of a loss of control and therefore need to be contained within the private sphere (Froggatt, 1998).

Gemma's efforts to appear calm and to control her anxiety also serve to protect the interests of her colleagues and patients:

I've always wanted to appear the calm person that anybody could come to because I think if you appear to be stressed people won't come to you because they're scared to make you more [stressed]. They'll say 'Oh she's too busy, she's too hurried, she can't cope with me asking questions just now', whereas if you're calm and relaxed they'll come to you. And then that's safer too because if they're coming to ask you questions about caring for people then ... if they're frightened to do that I don't know what they'll do. (Gemma: 476-483)



This concern is particularly relevant for nurses like Gemma, who work in departments where many of the nursing staff lack experience and therefore need to feel able to ask for advice and support. If Gemma's panic prevents these nurses from approaching her, both they and their patients are likely to suffer the consequences.

In addition to the need to keep calm in order to function in a stressful situation, participants stress the need to convey to patients that they are safe and in good hands.

I suppose you gave the impression to the patients that they were in good care, and that they were in a safe environment, to allay any fears that they would have just by being in such an *alien* environment. (Barbara: 247-249)

Maria and Elizabeth share Barbara's concern with being available to, and maintaining the trust of, patients (Maria: 146-149; Elizabeth: 196-197). Eileen also speaks of the fine balancing act involved in being with patients in their distress and maintaining enough professional self control to be able to help them (Eileen: 165-167). This concern to provide a reassuringly calm presence for her patients reflects an understanding of the nurses' role that is referred to by Armstrong in his study of changes in nurses' understanding of their relationship with patients. He cites a 1964 nursing textbook as exhorting nurses to remain calm and dignified under pressure in order that patients might draw comfort from them (Armstrong, 1983). He traces this perspective back to the late nineteenth century when Nightingale wrote that the nurse is there 'to spare (the patient) from taking thought for himself' (Nightingale, 1859, cited by Armstrong, 1983: 459). The message conveyed by these examples seems to be that a nurse who is unable to control her own feelings is of little use to either her patients, or her colleagues. Whatever the circumstances, she needs to remain strong and in control, a rock for vulnerable and distressed patients and a calming and reassuring influence on her colleagues.

## NEGOTIATING THE BOUNDARIES OF IDENTITY: THE STRONG NURSE VERSUS THE VULNERABLE PERSON

### A CARING PROFESSION?

Given the physical and emotional effort required to fulfil the expectations of a nurse, one might assume that releasing these feelings, and finding mutual support with colleagues backstage would be an important aspect of nursing culture. To some extent this seems to be true with several participants referring to the importance of 'letting off steam' with colleagues outside of work (e.g. Gemma: 819-822; Maria: 162-165). However, there appears to be a tension between the strong team ties that occur in some workplaces, and the accounts of some participants that suggest nurses are not particularly good at caring for each other. The difference between lay expectations of nurses as universally caring and supportive, and nurses' very different experience of themselves is noted by Eileen:

you always imagine that nursing is very *supportive* of each other and I think, as a student nurse, you quickly become aware that that's not always the case. (Eileen: 82-85)

Eileen's comments indicate how students as well as qualified nurses are expected to cope without support, despite their youth and lack of experience. Several participants speak of their early fears relating to everyday sights of disease and disability and to traumatic situations as well as to the possibility of being expected to carry more responsibility than they can cope with. For example, Barbara jokes, 'I probably never popped my head out of the sluice for the first year.' (Barbara: 120-121), and Emma speaks of her horror at being faced with faecal incontinence for the first time (Emma: 134-148). However, many face far worse situations, and the unsupportive attitudes of trained members of staff may make the transition to adulthood that often occurs at this time even more traumatic as Lindsay found:

The first time I'd come across death was in a general ward and they'd realised I hadn't handled it very well and said 'Right you didn't do that very well. You didn't handle it very well.' The lady in question, they couldn't get her to close her mouth so they put her false teeth in and bandaged her head to the back of the *bed* to try and keep her mouth shut, basically before rigour mortis set in. And I was quite upset with that. So the next time round, somebody died, they dragged me in to make sure that I knew what I was doing and could cope with it, and that was their way of making me deal with it. So

that was my first sign of death, my first occurrence of it so I didn't enjoy that very much. (Lindsay: 565-574)

My own first experience of death took place on my first day of training. I was asked to take the tea trolley round the ward, a task that should have proved easy enough. However, as I offered a cup of tea to a man sitting up in bed he went into cardiac arrest and died in front of me. I was suddenly surrounded by doctors and nurses rushing to resuscitate him and tripping over my trolley. I was told to keep going in order to reassure the other patients. I'm not sure that I was able to offer much reassurance as my fingers were welded to the tea trolley that had magically transformed into a Zimmer frame, supporting my shaking legs until the last cup of tea was served. When all of the activity had subsided I was asked to help lay out the body, but at no point did any of the staff ask how I was or offer any kind of support.

Given the emotional strength that is required to maintain self control, the lack of support available in many workplaces, and the intensity of the situations in which nurses often find themselves, it is not surprising that so many people leave nursing before qualifying, or choose not to practice at the end of their training. Despite their inexperience and youth, students are also expected to cope with whatever their work throws at them and to accept the disciplines of nursing without complaint. Two letters written in response to an article about student life published in the *Nursing Times* illustrate the point. In the article, a student complains that he has to work too hard for too little money. The first respondent writes:

Tell the kid to get a grip and get used to life in the real world ... Tell him from me that he should try a new profession (Raynis, 2002: 20)

In the second response, entitled *Students Should Perk Up and Get a Life*, another student states that she is sick of hearing people complain about student life and asks:

if it were easy, would our training have any value? ... aren't we all exactly where we want to be – on the wards? (Young, 2002: 20)

A similar perspective on the harshness of training appears in Kiger's study of students' images of nursing in which they see the difficulties they face as a test to be passed in order to prove their motivation (Kiger, 1992: 118). In the light of such attitudes it is easy to understand why this period of a nurses' life has been described as a 'baptism of fire' (Salvage, 1985: 68; Mackay, 1989: 16).

Throughout participants' accounts, qualified nurses' failure to support each other is a recurring theme, and several speak of how their behaviour has been shaped by a fear of being seen as weak (e.g. Liz: 564-567; Mary: 205-221; Elizabeth: 348-369; Lindsay: 277-288; Lesley: 972-975). For Mary and Liz this fear relates to physical weakness, while for Lindsay, Lesley and Elizabeth the fear of being seen as emotionally weak prevented them from asking for support in difficult circumstances. Their fears support the observations that nurses commonly portray emotion as weakness (Smith and Gray, 2000), or as an ever-present danger that threatens to overwhelm them if not tightly controlled (Froggatt, 1998). The widespread emphasis on individual strength and ability to cope is apparent in the large volume of nursing literature on stress in nursing in which nurses are presented with ways of improving their individual coping skills (e.g. Bond, 1986; Hingley and Cooper, 1986; Handy, 1990; Claus and Bailey, 1980). The possibility that the stressors that nurses have to cope with could be eliminated or reduced is largely overlooked. A similar perspective is demonstrated in a *Nursing Times* article that offers nurses a list of measures that they could take in order to improve their job satisfaction. These include managing stress, staying motivated, finding support and staying focused on the 'real' things, i.e. providing good care rather than 'drowning in the disempowering policy and procurement culture' (Radcliffe, 2002). The emphasis on individual strength and coping is also reflected in Birch's suggestion, cited in chapter one, that personality tests could be used during recruitment in order to determine which candidates are most likely to cope (Birch, 1975). The common perception appears to be that a 'failure' to cope reflects a personal inadequacy or weakness rather than a lack of support, or the excessive demands made upon nurses. People are divided into those who are strong enough to cope with anything, and those who are not. This is a polarisation that lies at the heart of the dominant discourse of nursing.<sup>56</sup>

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<sup>56</sup> A similar polarisation occurs within the police force and can be seen in the comment made by a 'stress academic' on a Metropolitan Police Force steering committee that police suffering from post traumatic stress disorder should not be compensated 'because they are being rewarded for failure' (cited by Hampshire, 2000)

## A POLARISATION OF ROLES: STRONG NURSE OR NEEDY PATIENT?

Within the discourse of the good nurse, a clear distinction is drawn between nurses as strong carers, and patients as vulnerable and needy people. Indeed some participants describe having struggled to accept the role of dependant patient when they were hospitalised (e.g. Eileen: 426-458; Jean: 431-438). Mary's account provides a good example of a nurse who cannot bear to feel vulnerable:

- Alison        How does that make you feel then, when you're looking after people?
- Mary         Needed. You feel needed. I mean I've always been there. I always had people there that look to you and you're supposed to know what's going on and so that's the position I'll always wanna be.
- Alison        Has the position ever been reversed when you've been ill and you've been dependant on other people?
- Mary         Oh aye. I was in hospital two years ago. Initially I was pretty bad but then I started making my own bed and tidying up around the room and going out to the drug trolley and saying 'well can I have that?' They says 'Mary, you're a patient. Will you go back to your bed!'
- Alison        (laughs) So how did you feel about being a patient?
- Mary         Oh God, it was very strange. You just feel vulnerable. You feel vulnerable. I didn't like it at all. It's not a position I want to repeat, I have to say because it's a different role isn't it? You see it from the other side, nah, I didn't like it. 'Get me out of this Mum, please'. (Mary: 345-362)

Despite the rather ironic call for help from her mother, Mary's identity seems to be bound up with being a strong person who cares for others. The experience of being dependent upon others challenges this self-image, undermining her feeling of strength. Instead of being needed, as a patient she was the needy one. Mary coped with her feelings of vulnerability by attempting to move back into the familiar role of nurse but was put back into her place by those charged with her care.

This example points to the way in which nurses polarise the roles of strong nurse and vulnerable patient. Mary rejected the latter role but in so doing she appears to have made her nurses very uncomfortable. They were faced with a person who blurred the boundaries, refusing to accept the dependant and vulnerable role they expected her to perform. In sending her back to bed they seem to have been trying to re-establish these boundaries. In the accounts of other participants who have been hospitalised, there is the suggestion that some nurses faced with this situation

use a very different tactic. Jean, Elizabeth, Robert and Lindsay all speak of nurses who become patients being shunned by the nurses on their ward. The reasons for this phenomenon are not clear, but Jean suggests that there is an assumption that nurses do not need any explanations as they already have all the information they need (Jean: 677-704). While this might explain the poor communication it does not explain why Jean was left alone and covered in her own blood for several hours after the birth of her daughter. Despite the fact that the nurses<sup>57</sup> themselves told her that they weren't busy (Jean: 731), she had to leave her baby with a stranger and walk to the bathroom to clean herself up to avoid frightening her older child who was due to visit. As a result she vomited and began bleeding and was scolded by the nurses who had not been there to help (Jean: 734-735). In an account of her experiences following immediately after the birth of her daughter, Schroeder describes how she was shunned by nursing staff and told by a doctor who had just informed her that her daughter had cardiac failure 'You're a nurse. Call the intensive care nursery if her respirations go over 60.' (Schroeder, 1998: 14). Lindsay also describes being left alone with her small son for three days after his emergency admission to hospital, and attributes this neglect to her being a nurse without elaborating upon the reasons (Lindsay: 440-461). I have also shared this experience of being shunned to the extent that my son and I received no meals and saw no staff over a period of fifteen hours after he too underwent an emergency operation. It is notable that most of these accounts involve the children of nurses. This may create a doubly ambiguous situation in which the adult concerned combines the role of dependant patient with the 'strong carer' roles of nurse and mother. Robert, who speaks of several nursing acquaintances who have been 'shunned' as patients, offers an alternative explanation. He suggests that nurses fear that nurse/patients will judge their practice unfavourably (Robert: 465-587). While there is insufficient evidence from these few stories to provide any clear understanding of why those concerned were shunned, they indicate the existence of a phenomenon that merits further study.

The examples cited above point to a discourse of nursing in which nurses are not only expected to appear strong in front of their patients, they are expected to be

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<sup>57</sup> Although Jean's account relates to experience of childbirth she speaks of the behaviour of nurses working on the postnatal ward rather than midwives.

strong people who do not need support and who are able to bear any load that is placed upon them without complaint. These accounts suggest that even those who do not reject their vulnerable side experience pressure to conform to the image of the strong nurse who has no needs of her own. A nurse who fails to control her feelings of doubt, fear, or neediness, who expresses revulsion, prejudice or boredom, who falls sick or fails to be there as a strong and reliable anchor for her patients, challenges this dichotomy and breaks her commitment to place the needs of her patients first in all circumstances. It may be that a similar logic applies here to that expressed by Liz in relation to behaving like a professional outside as well as inside the workplace.

I think if you're putting up a pretence when you're coming into work then you'll let your guard slip at some point because, because of the stress in the nature of the job. (Liz: 226-229)

From this perspective, a nurse who only appears to be strong may not be able to maintain the façade under all circumstances, risking a collapse that could harm her patients. However, the emphasis on personal strength may not simply serve to protect patients. Participants' reflections on issues of strength and weakness suggest that identification of oneself as a strong carer also serves to protect the nurse from her own feelings of weakness.

## UNDERSTANDING THE DISCOURSE OF THE SUPER-NURSE

In this chapter I describe a discourse of nursing that creates an expectation of physical and emotional strength without boundaries. A good nurse is not just physically and emotionally strong, she is invulnerable; she does not just work to a high standard, she never makes mistakes. This is not just the discourse of the good nurse, but the super-nurse.<sup>58</sup> The extreme nature of this discourse raises two fundamental questions; why is commitment to such a harsh way of life so

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<sup>58</sup> The term 'super-nurse', which was used by Lesley to describe other people's perception of her role, is a familiar one for nurses since it is often used to describe the new 'nurse consultants'. As such it implies superiority over other grades of nurse. However, I use the term to describe the discourse of the good nurse that imposes expectations of super-human strength upon nurses of all grades. This application of the term can be seen in a weekly cartoon in the *Nursing Times* entitled 'Super nurse' in which the main character is an ordinary nurse facing the extraordinary demands of nursing in the NHS.

important to nursing; and why do individual nurses abide by the rules of this discourse? To some extent, the answer to the second of these questions is that many people do not accept the way of life that the dominant discourse of nursing dictates. Ideas of service and self-sacrifice sit uneasily with the emphasis on individualism and material acquisition that characterise much of modern British society. Not only has the traditional recruitment pool of female school leavers diminished in recent years, but also there are now far more attractive, and materially rewarding, career opportunities available to women. Furthermore, of those people who do choose nursing, many do not complete the course, while others decide not to practice after qualifying as nurses. However, this study focuses on those nurses who, on achieving registration, do accept a commitment to nursing. Participants' accounts indicate that this dominant discourse does not actually reflect the expectations of many qualified nurses. Furthermore it conflicts with wider societal attitudes towards self-sacrifice, service and commitment. However, it is a discourse that persists and continues to shape nurses' daily lives. In the following section I explore the rationale behind the ideas and expectations described above and show how a number of factors combine to ensure that nurses continue to conform to the role of the super-nurse.

## **PROTECTING THE INTERESTS OF PATIENTS**

The most obvious answer to these questions lies within the discourse itself. The fundamental principle underpinning the discourse of nursing is that patients are people who matter, and not simply objects to be processed. Nursing is much more than a job, it is a service and in order to provide the service that patients deserve, nurses must demonstrate a commitment that goes far beyond the requirements of a simple job. A nurse's work is seen as special and privileged (Lesley: 677-639; Elizabeth: 489-490, 497, 506; Claire: 372-377, 423-425, 636-639; Valerie: 366-368), something that nurses are expected to recognise and respond to by showing a commitment and respect for the people they care for:

*It's a very privileged position. I have met people who I've thought 'Well you're not actually that caring.' But I like to think that when I'm sitting with them [patients] that I could try to imagine 'If that was me, or someone I loved...' I can't really tolerate much this 'Well you know it's a patient, and that's her.'* (Claire: 636-649)



For Claire, a commitment to nursing means caring about patients as human beings, a perspective that is shared by Judy:

I think there's always a chance that people will say 'Oh, they're old' or 'They're dirty' or 'They're the wrong colour' or whatever and somehow that makes them less important, and it doesn't matter if you don't do that right or this right. And I think you have to care about your patients and also to care about your standards as well (Judy: 324-329)

Both of these nurses describe the ethic of care that I described in chapter three, that is, since patients are people, what happens to them matters. This perspective has profound implications in terms of the effort that nurses are expected to put into their work. The lack of boundaries to the level of endurance expected of them mirrors the lack of clear boundaries to their role and consequently to their workload. A boundless workload requires a boundless degree of effort if nurses are to fulfil their commitment to protecting patients from dehumanisation and to providing them with the best possible care.

### **PROTECTING THE INTERESTS OF NURSING**

While a strong emphasis on the need for commitment can be seen as serving to protect patients, they are not the only group that benefits from this discourse. Ideas of nursing as requiring a commitment to self-sacrifice in the service of others also benefit nursing as an occupational group. This can be seen in the professional discourse in which professions are described as receiving power and control over their field of expertise in return for assurances that their members can be trusted not to abuse their privileged position. The importance that nurses place on maintaining the good name of nursing can be seen in Heather's comments on the care given to her father during a period of hospitalisation. She describes how he was inadequately monitored and 'kicked out' of his bed for another patient an hour before the consultant came to tell him that he could go home (Heather: 173-174). She describes feeling embarrassment at the behaviour of his nurses since the hospital was one that she had worked in and spoken well of to others. Heather felt personally let down by her fellow nurses whom she also saw as letting down their profession (Heather: 171-177).

While Heather speaks of nurses letting their profession down, the benefits to nursing of a membership that is committed to a discourse of self-sacrifice, respect for patients, hard work and discipline go beyond those that accrue to any occupation that achieves recognition as a profession. Nursing is different from other occupations that describe themselves as 'professional' in that a large proportion of the work involves close bodily contact with people who are marginalised within society, for example, the sick, the elderly and the mentally ill. Nurses deal on a daily basis with that which most people view as disgusting or frightening, with bodily fluids, with dirty wounds, with death, disease and decay. In other contexts, such work is usually perceived as being menial and dirty, stigmatising those who perform it. For example, Saunders includes 'heavy physical, dirty or socially demeaning work' as contributing to:

a social image of diminished competence, inferior intelligence, minimal if any training, the lowest level of skill and a reduced capacity to make a useful and telling contribution to the overall wealth of society. (Saunders, 1981: 1)

In her history of South African nursing, Marks writes of 'polluting domestic labour' and points to the way in which 'dirty work' in South Africa is delegated not only to the lowest classes in society, as happened in Britain, but also to those who are seen by some as the 'inferior races', i.e. blacks (Marks, 1994).

The potential for nurses to be degraded by the nature of their work can be seen in the descriptions of pre-Nightingale nurses as drunken, irresponsible slatterns (e.g. Bradshaw, 1994; Marks, 1994; Yule, 1999). In order to replace this image and recreate nursing as an occupation fit for 'respectable' women, Nightingale and her peers placed great emphasis on the moral character of nurses. To achieve this goal they may have exaggerated and over-emphasised the negative image of pre-Nightingale nurses (Williams, 1974). As women performing intimate tasks for patients, who were often male, nurses needed a way of protecting their reputations. This was achieved by stressing the image of nurses as angels, detached and virtuous, protected from the sexual advances of patients and the stigma of their work by the sanctity of their vocation (Carpenter, 1978; Marks, 1994). Great care was taken to ensure that only the most suitable women were accepted for training. As Carpenter argues, a 'harsh authoritarian regime' and a 'cloistered life' deterred 'unsuitable' recruits and uncovered those who weren't totally committed

(Carpenter, 1977: 172). The current harshness of the dominant nursing discourse and the high wastage among students can, in part, be seen as originating in this early emphasis on a feminine vocational commitment. The continuation of this emphasis on virtue in training has been noted by Rafferty who claims that:

Nursing education has been characterised by the inculcation of moral values and virtues rather than intellectual prowess (Rafferty, 1996: 1)

Beyond the boundaries of nursing the image of the angel persists and is reflected in Porter's claim that nurses receive an honoured place in society as a result of their image of caring selflessness (Porter S., 1998). As Margaret shows in chapter three, this 'honour' is a double-edged sword that is resented by many nurses as patronising and rooted in a disdain for the dirty work that they do. However, although many nurses now reject the imagery of the angel, and students are no longer confined to nursing homes with strict curfews and rules regarding male visitors, being a good nurse still carries a moral dimension. This can be seen in the link that Christine makes between failing to meet her standards and being a 'terrible person' (747-752). Mark also makes this connection, criticising colleagues who use the idea of nursing as a vocation to claim, 'Well I must be a good person because I'm a nurse.' (Mark: 913).

The way in which an image of vocational commitment and self-sacrifice serves to enhance the status of nursing is the subject of a paper by Williams (1974). She claimed that when nursing is viewed as a vocation rather than a job, both nurse and patient avoid the respective stigmas of low status 'dirty work' and childish dependency. Her belief that nurses who see their work as privileged are likely to show a greater respect for their patients than those who see nursing as menial, dirty work, is echoed in the accounts cited above. Williams also argued that a vocation sheds a sacred light on patients, making the work a privilege and nurses special. If nursing is seen simply as a job, the patient becomes no more than a dependent child or an object to be processed, and the work carries the stigma of servility, and an association with bodily fluids. The status of the nurse plummets accordingly and, given the intimacy of nursing, the objectification of the patient and the denigration of the nurse, creates enormous potential for abuse. As Marange argues dehumanisation is the first step towards enabling one person to abuse another (Marange, 1989). Thus, the identification of nursing as a special vocation is

important both for the patient and the nurse (Williams, 1974). For nurses, living up to the high expectations of the super-nurse is not simply a matter of protecting the interests of patients. In demonstrating their deep commitment they ensure that the reputation of nursing is maintained.

Thus far I have described the rationale behind the discourse of the super-nurse. Although this creates a powerful discourse with which many nurses comply, participants' commitment, expressed in a willingness to submit to these expectations is not simply a matter of compliance, but of genuine feeling. As I have shown, some have come to identify so strongly with the role of nurse that they no longer accept the vulnerable side of their identity. In the following section I show how participants' acceptance of the demands made upon them also draw upon wider societal discourses and the experiences they have prior to becoming nurses.

## **EARLY SOCIALISATION INTO A CARING ROLE**

### **The Discourse of Women as Strong Carers**

In chapter four I described the discourse of a feminine vocation to care in which self-sacrifice in the service of others is pivotal. Despite the appellation 'the weaker sex', this discourse portrays women as having an enormous capacity to endure. Women's expectations of themselves are shaped by this feminine discourse of caring self-sacrifice long before they contemplate a career in nursing. For example, both Judy (678-679) and Anne attribute their tendency to work when sick to the influence of their mothers:

- Anne        My children will tell you that they had to be dying on their feet before mother would let them stay off school and I don't think I have a great sympathy for people who are ill.
- Alison      Do you think that's come from being a nurse, or were you always like that?
- Anne        Oh I think it's something I've always been. Literally you had to be collapsing on the doorstep before she [my mother] would say 'No, you can stay at home'. It was very much a case of illness was something that you could get over it. You had a cold. It didn't matter. Just get on with it. It will get better. (Anne: 153-163)

For Anne's mother, illness was something to be worked through and overcome, an attitude that she passed on to her daughter. A similar expectation can be seen on page 248 in Liz's claim that her attitude to sick leave reflected her upbringing. The importance of girls' socialisation into strong, caring roles is also apparent when Lindsay speaks of her tendency to play the strong mother figure with her friends and family outside of work (Lindsay: 76-85). She too sees this as a role that she developed before entering nursing.

The impact of this feminine discourse upon nursing is recognised by Valerie who jokes that being a nurse is sometimes like living in a big convent (Valerie: 732), I asked if she sees any connections between the expectations of self-sacrifice and the female domination of nursing:

It's probably an extreme example of being a woman; it's a big part of the feminine culture. I think women in general but more so in certain disciplines, social work and nursing and some of those where it draws the ones who have the biggest issues. But I think it is part of a woman (Valerie: 738-743)

The connection that Valerie makes between gender and self-sacrifice can also be seen in Bullough et al's study of newly qualified teachers. They claim that female teachers face a 'fundamental and particularly female dilemma' in that nurturing is at the heart of their self-concept and satisfaction at work but in order to fulfil their working commitments they must sacrifice their health and the welfare of their families (Bullough et al, 1991).<sup>59</sup> This observation resonates with Gilligan's work on women's moral development in which she argues that women tend to frame ethical dilemmas in terms of care and responsibility in relationships, in contrast with the masculine emphasis on rights and rules (Gilligan, 1995). For Gilligan, Tschudin's assertion that nurses matter too, simply because they are people, is an example of the most mature level of moral development. To reach this point a woman must reconcile the moral imperative to care for others with the need to assert her right to care for herself.

It is precisely this dilemma - the conflict between compassion and autonomy, between virtue and power - which the feminine voice

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<sup>59</sup> The gendered nature of teaching, and its vocational status, create a situation in which there appear to be many parallel experiences and expectations between the two groups. A comparative study of the two occupations could provide valuable insights into the discourse of feminine self-sacrifice at work.

struggles to resolve in its effort to reclaim the self and to solve the moral problem in such a way that no-one is hurt. (ibid.: 254)

This approach to moral reasoning suggests that those nurses who decide to leave nursing in order to protect their own health and wellbeing are demonstrating strength and maturity rather than weakness and a lack of commitment to their patients.

Having reflected on the general link between self-sacrifice and femininity, Valerie goes on to say that she has observed similar attitudes among her male colleagues:

... I'm trying to think back through the male nurses that I know. They were the same way. There just weren't so many of them. (Valerie: 742-743)

Valerie's observation of male nurses' tendency to share the emphasis on self-sacrifice could be understood in several ways. It may be that men are socialised into the 'feminine' discourse of nursing, or that certain men with these values are attracted to nursing. Her comment reinforces my own observation that the male nurses in this study are more like their female colleagues than different. Since gender differences are not the focus of this study it is not possible to draw any conclusions from this small number of male nurses but this would be a useful area for further study.

The parallels between the discourse of the good nurse and the good woman create problems for men in nursing who, by definition, do not fit the criteria for a good nurse/woman. For example, Robert recounts his first experience as a student nurse when he was shown to his room in the nurses' home:

you had the traditional male start to it; the minute I got there I was staying in the hall of residence for the first three months 'til I found somewhere to live. I go to my room and there's this pile of dresses waiting, and hats, and I'm not even sure they're my *size*. We had such difficulties we ended up, myself and this one other guy who started, they managed to find us some tunics but we went and bought the rest ourselves and we got reimbursed because they just couldn't get us nursing uniforms. (Robert: 191-199)

Robert's story reflects attitudes and ideas of nurses in the 1970s but the situation seems to have changed very little by the time Mark trained in the early 1990s. He comments on the way in which the epithet 'male' is always attached to his title of nurse, indicating that there is a significant difference between a 'nurse' and a 'male

nurse' (Mark: 198-207). He also speaks of his female colleagues' doubt about the abilities of 'male nurses':

I think they just don't see men as being competent at being nurses. They perceive men to be lazier<sup>60</sup>, to be less hands on I think, to be typically less caring or whatever. Whereas I pride myself on the level of basic care that I give. I'm very much the old school you know, if you get the patient comfortable, pillows right, basically look at them from top to toe when you go in (Mark: 210-217)

As 'male nurses' Robert and Mark work in a world that continues to be constructed around a feminine discourse of caring that has failed to accommodate the number of men within its ranks.

### **Early Experiences of Being a Strong Carer**

The identification of oneself as a strong carer is not simply the product of socialisation into discourses of femininity. The experiences of several participants suggest that they have identified themselves as carers from an early age, and that this contributed to their decision to become nurses. For Mary, a lifetime of caring for siblings, nieces and nephews has contributed to her identification of herself as a carer:

it's just all I've known, all my life. That's why probably I've not got any kids of my own. I've just been surrounded with kids all my life. And I just do this. (Mary: 318-320)

While reflecting upon how they came to choose nursing, Mary (308), Robert (54) and Mark (11-13), all draw upon the fact that they grew up in large families and took on the responsibility for younger siblings. Mark also associates becoming a nurse with early experiences of mediating between his parents during times of family strife:

I always was the mediator between Mum and Dad. You see all these qualities of a nurse being thrown at you and I just thought 'Well, I'm not a bad listener ...' (Mark: 95-100)

While reflecting on why she became a nurse, Valerie also draws upon a similar experience in her childhood role as carer for a mother with manic depression (Valerie: 698-700). She attributes her career choice to a series of early bereavements

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<sup>60</sup> This characterisation of male nurses appears in Kate's reflections on men in nursing (Kate: 576-585)

that triggered a desire to learn more about death: nursing provided the proximity that she sought in order to understand death better (Valerie: 695-698).

Having considered her own motivations, Valerie takes a broader perspective, suggesting that childhood experiences shape other nurses' career choices:

It's funny, I had about eight managers in different shifts and areas. We were meeting as a team one time and something came up about abuse as a child, or as an adolescent, and one person was having a rough time and we were trying to give them support and they brought up this issue. Ended up *every single one* of us in the room had been abused in some way as a child or an adolescent. I thought 'Somebody needs to study that sometime.' And it was about fixing up and I'm sure going into paediatrics has a lot to do with that. (Valerie: 673-683)

Valerie concludes that, for some people, nursing provides an opportunity to 'fix' other people's problems that serves as a means of avoiding their own issues. She has worked hard on herself to overcome this tendency but still sees it at work in other nurses.

I spend a lot of time working on *me* to learn how to take care of me because I didn't; I thought I should fix the whole world but not me. And it's also a good way of *avoiding yourself*. If I was really, really busy I'd never have to look at any of my issues...

... I think all nurses that I talk to, something that draws us to the nursing profession is this need to take care of, or fix things, and when I talk to nurses we've all have this background where we've had to be carers or felt like if we could be carers we could make it *better*, whether in the home environment or whatever. Yeah it's this need to protect people, and it's about protecting ourselves. (Valerie: 657-662, 666-671)

Her analysis resonates with other participants' references to the need to be needed (Gemma: 706-711; Mary: 336-349; Anne: 561-574, Claire: 616-634) and reflects Mark's understanding of why people choose nursing:

So why are people nurses? Why do people need to be needed? Maybe there's something about nurses or just me generally. Is there something about needing to be useful to other people? (Mark 944-947)

This phenomenon of needing to be needed may explain why, for some nurses, it is important to identify themselves as strong carers, rejecting a vulnerable side that is too painful to accept. This identification of themselves as strong carers seems to occur at an early stage in their lives, contributing to their decision to become nurses.



For these people, leaving nursing may not be an option since it would challenge an aspect of their identity that is deeply ingrained. By bringing these ideas of what it means to be a carer in to nursing, nurses contribute to the perpetuation of a nursing discourse in which the separation of the strong carer from the weak dependant impacts upon the behaviour of those who are more prepared to accept their own vulnerability. This is an issue that I explore further in chapter six.

### **A STRENGTH THAT SERVES THE SYSTEM**

The benefits of a continuing discourse of the self-sacrificing super-nurse are not limited to nurses and the patients they care for. A workforce that expects to work long hours without being compensated, that accepts the need for intense hard work and stresses the importance of individual coping over support or change also suits the NHS. Not only does it receive a great deal of unpaid labour, but expectations of self-sacrifice create a climate in which nurses either willingly comply with the *status quo*, or feel unable to challenge it.

At times, nursing seems to feed into the very managerial trends that nurses complain about. For both Lindsay and Mary, nursing attitudes towards physical weakness seem to fit in with broader bureaucratic attitudes towards unproductive workers. Since they were unable to work to their full capacity, in bureaucratic terms they were not efficient workers. Many women in particular experience the consequences of this attitude when pregnancy limits their physical capabilities and endurance. In September 2003 the Equal Opportunities Commission launched an enquiry into discrimination against pregnant women at work, as they receive more complaints on this subject than any other (BBC, 2003i). As a nurse, Lindsay's situation during her pregnancy was compounded by working in an occupation that made heavy physical demands and, as I have demonstrated in chapter four, continues to deny the reality that its members are no longer exclusively single women. The discourse of the super-nurse is not simply a product of the occupation itself, it is strengthened and exploited by managers and politicians who praise and encourage nurses' commitment, loyalty and altruism (e.g. Blair, 2002), or criticise them for lacking these virtues when they resist the *status quo* or decide to leave nursing altogether.

## **NEGOTIATING THE BOUNDARIES BETWEEN THE SUPER-NURSE AND THE HUMAN BEING**

In this chapter I describe a dominant discourse of nursing as an occupation that demands a great deal of self-sacrifice from its members. Commitment is held up as the defining criterion for a good nurse and, in order to prove her commitment, a nurse must be prepared to sacrifice her own physical and emotional needs in the name of her work. Furthermore, nurses are not only expected to comply with an outward display of commitment at work, they are expected to identify with their working role both in and out of work, allowing it to shape their whole way of being in the world. The role of 'nurse' therefore has the potential to push aside the vulnerable aspects of an individual's identity and to intrude upon her personal relationships outside of work. In the following section I explore the problems that this discourse of the super-nurse creates for nurses as normal people with needs of their own.

### **NURSES ARE PEOPLE TOO**

The first issue that arises in relation to the discourse of the super-nurse is the unrealistic expectation that nurses, as human beings, have the capacity to fulfil and maintain a super-human level of endurance and self-sacrifice. However strong a nurse is, she is still ultimately a human being faced with the demands of an intrinsically stressful job. As district nurse Zoë Lloyd argues:

Anyone who believes a doctor or nurse can somehow fight off mental illness like a Jedi Knight is deluding themselves. (Lloyd, 2002: 24)

Nursing is an occupation in which one is confronted daily with the traumatic and the distressing. Nurses are faced with the intense emotions of patients, relatives and friends as well as having to deal with their own emotional responses that may be heightened by a resonance with personal experiences. For example, Maria describes how she struggled when caring for a patient with cancer shortly after the death of a relative from the same disease (Maria: 525-530). Her distress was compounded by the personal doubts it raised regarding her ambition to work in oncology. Lindsay also describes how her personal circumstances intensified the

emotions engendered at work. After caring for a child with severe burns who subsequently died, she describes how she found herself visualising the burns on her own children (Lindsay: 269-270). For Lindsay, being a mother adds a whole new emotional dimension to her work, an experience that played a significant part in my own decision to leave nursing. As a new mother, I returned from maternity leave to work alongside a health visitor in an area where many clients were single parents, and poverty, drug use, prostitution and child abuse were common. I found it impossible to muster the necessary strength to distance myself from the struggles of the mothers I was there to support, and eventually broke down in tears and was sent home after one of the most miserable weeks of my life.

However strong a nurse is, she remains a human being. Although some nurses reject this reality, identifying completely with the image of the super-nurse and bearing an enormous load alone, they risk their own health and sanity in doing so. Within psychiatry, the tendency to deny negative feelings is understood as a mental disorder, or as a stage through which one passes before facing and resolving the issue in question. Indeed, as students, nurses are taught about denial as a response to loss, and their role in helping others to work through it (Kubler Ross, 1970). However, as strong carers, they are expected to deny their own feelings of fear, anger or loss. For those nurses who retain a sense of their own human vulnerability, this discourse places them in a situation where there is often no support available or where they fear to ask for help, as I demonstrate in chapter six. In previous generations, the group coping mechanisms described by Menzies facilitated individual nurses' ability to cope. However, although some of these mechanisms have survived they no longer fit within the dominant discourse of holistic care in which a genuine nurse/patient relationship is understood as being a key therapeutic tool (e.g. Savage, 1995; Tschudin, 1999; Salvage, 1992; Antrobus, 1997). As Henderson argues, nurses who seek to involve themselves emotionally in their work have to negotiate the constantly shifting boundary between involvement and detachment. They must find the balance that enables them to support their patients while remaining sufficiently detached and in control to maintain a 'helping relationship' and to protect themselves (Henderson, 2001). The tension between protecting oneself through 'professional distance' and putting on a front, and the need to be genuine in order to establish a helping relationship lies at the heart of the

second problem that nurses face as a result of the imperative to remain calm at all times.

### **THE DILEMMA OF REMAINING GENUINE WHILE PRESENTING A STRONG FRONT**

For some participants, putting on a front (Kate: 716-724) or a face (Barbara: 642-654) in order to appear calm and in control is an acceptable part of being a nurse. Indeed Anne compares nursing with teaching and acting, describing all three occupations as requiring one to 'put on a show' (Anne: 106-121). Hochschild described this behaviour in her seminal work on emotional labour in the airline industry. She described emotional labour as activity conducted as part of paid employment that involves:

the management of feeling to create a publicly observable facial and bodily display (Hochschild, 1983: 7).

The same skills applied in the private context are described as emotion work or emotion management (ibid.: 7). This division is challenged by James who argues that it masks the important contribution that women's emotional labour makes in facilitating the labour of others, whether it is carried out in the public or domestic sphere (James, 1989).

People engaged in emotional labour learn to behave in ways that contradict their personal feelings, to compartmentalise their lives so that private concerns are set aside for the duration of a shift. This is often done in order to provide a service for others that involves managing their emotions too. Hochschild echoes Goffman's focus on performance, describing one of the key skills of emotional labour as 'surface acting' (ibid.). This refers to the way in which 'we are capable of disguising what we feel, of pretending to feel what we do not.' (Hochschild, 1983: 33). Nurses' use of surface acting can be seen in Lesley's comment that she was a 'master of disguise' when covering up her distress prior to leaving nursing (Lesley: 499), as well as in the many examples cited above in which participants have masked their real feelings.

Although some nurses accept acting as an essential nursing skill, others reject the idea of putting on a front and emphasise the importance of being genuine. For example, James explains that he doesn't change into a uniform and become someone else, claiming 'What you see here is what I am.' (James: 392-342); Margaret

sees her genuineness as one of the positive attributes that she brings to nursing (Margaret: 174-180), and Elizabeth comments that 'I *try* and do my best as an individual and be the person that I am'<sup>61</sup> (Elizabeth: 344-345). Sue rejects the label of nurse altogether, stating that she is herself at work, if a little better behaved (Sue: 435-449). This emphasis on being oneself with patients is an important aspect of the holistic philosophy of nursing care in which nurses seek to address not only the physical needs of patients, but also their psychological, spiritual and social needs. In so doing they need to develop a genuine relationship with their patients.

This emphasis on being genuine can be traced to the influence of humanistic psychologist Carl Rogers, on nursing (Aranda and Street, 1999). One of Rogers' key ideas regarding the 'helping relationship' is that the helper must be congruent:

If in a given relationship I am reasonably congruent, if no feelings relevant to the relationship are hidden either to me or the other person, then I can be almost sure that the relationship will be a helpful one. (Rogers, 1961: 51)

According to Rogers, a person who masks her feelings from either herself or her client will damage the sense of trust in their relationship, and without trust the relationship is unlikely to be helpful. Rogers does not suggest that helpers should allow their emotional responses a free rein in the way that Gemma describes, rather, they should be able to recognise feelings that impact upon the relationship and acknowledge them to themselves and their clients. Thus, according to this theory of helping, a nurse who feels grief will have a better and more trusting relationship with a dying patient and his relatives if she allows them to see that feeling.

While this philosophy demands that the helper should control her feelings in order to maintain the focus on those of the client, it conflicts with nurses' belief that they must not allow their negative feelings to show at all. The conflict between the two sets of expectations is even greater when a nurse rejects her vulnerable side completely. As Armstrong notes:

In its current image a relationship is a two way affair: acknowledgement therefore of the patient's emotional needs and responses without recognising that the nurse too has a similar

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<sup>61</sup> Elizabeth speaks of trying to remain genuine in the present tense although she is no longer practising as a nurse. This may mean that she values genuineness in all settings or she may share Lesley's tendency to speak as if she is still nursing.

repertoire suggests that the intimate relationship is more of a stance than a reality. (Armstrong, 1983: 458).

While the account of nurses' understanding of their role, outlined in chapter three, suggests that many have accepted the holistic philosophy of nursing based in the therapeutic relationship, the expectations of nurses described in this chapter seem to conflict with that philosophy. The question here reflects a central thread in identity theory, that is, how can one retain a sense of integrity when different performances are required in different situations? How can a nurse be genuine without sometimes showing her weakness, a form of behaviour that is unacceptable within the dominant discourse of the super-nurse?

The clash between a desire to be genuine with patients, and the need to present a front in order to be accepted by patients, appears in the work of Aranda and Street (1999). During a series of focus groups, in which nurses explored their relationships with patients, participants spoke of the need to behave like a chameleon, fitting into the patient's social context in order to develop a sense of trust and connection. In playing the chameleon, these nurses saw themselves as controlling and manipulating patients' behaviour in ways that left them feeling guilty and ashamed. Hochschild also identifies negative feelings associated with the presentation of a false front, noting that as a result of spending so much of their working lives engaged in emotional labour, some airline stewards begin to feel cynical about themselves, believing that they are 'phoney' (Hochschild, 1983: 181). Mark's experiences on the wards reflect a similar sense of discomfort regarding instances in which he felt that he was not really being himself. As a gay man, he often found himself in situations where he felt obliged to dodge questions that related to his personal life.

You can see people wondering about you. They always throw in a couple of 'So are you married then?', (laughs) and sometimes you want to say 'Well actually yes, I've got a boyfriend.' [but] you just couldn't say that, (Mark: 627-631)

Although he wants to be genuine and put himself into his work (Mark: 290-295), Mark seems to be afraid that by revealing this aspect of himself he will damage the relationship with his patients. This dilemma points to the crux of the problem of being committed to an occupation that requires one to be a respectable role model for others, and a constant pillar of strength, whilst remaining genuine in order to build a trusting relationship with one's patients.

One means by which nurses cope with this dilemma is their engagement in what Hochschild describes as 'deep acting'. This refers to a situation in which,

display is a natural result of working on feeling; the actor does not try to *seem* happy or sad but rather expresses spontaneously ... a real feeling that has been self-induced. (Hochschild, 1983: 35)

The use of this technique appears in several participants' accounts. For example, since a good nurse does not respond to anger with anger, Jane deliberately changes her normal response to a personal attack from a patient's relatives by reframing the situation:

You have to try and keep calm and just remember that, they're angry because they're worried and if it was your Mum or Dad you'd probably feel the same way and just try and calm them down and explain things to them. (Jane: 311-313)

In suppressing her anger and transforming it into understanding acceptance, Jane conforms to an expectation of the good nurse raised by several other participants, i.e. that a good nurse has broad shoulders and can accept abuse and unfair criticism (Christine: 783-796; Jean: 999-1003; Elizabeth: 163-170; Eileen: 586-589). These comments reflect those of Mollett who states that a nurse must 'be content to bear unmerited blame without murmuring' (Mollett, cited by Jolley and Brykczynska, 1993: 14). This expectation may explain the results of a survey conducted in Scotland at the time of these interviews in which 61% of nurses who had been assaulted stated that they thought that it was 'a part of the job' and so had not reported the incident (UNISON, 2002). This belief is cited by Rippon (2000) as one of the reasons why there is so little research into aggression against nurses, despite the fact that they frequently face both verbal and physical abuse from patients and from relatives (Vousden, 1998; Brennan, 2000; Daly, 2001b; UNISON, 2002, McKenna et al, 2003). Deep acting provides one means of coping with these attacks in an 'acceptable' manner but the costs of this particular strategy can be high. Hochschild describes how airline stewardesses can experience what she describes as 'emotive dissonance' (Hochschild, 1983). They spend so much time managing their feelings in order to meet the needs of others that they lose touch with their real feelings. By engaging in emotional labour in order to fulfil expectations of the super-nurse, nurses also risk losing touch with their true feelings and so with the human aspects of their identity.

### **GIVING IT ALL AWAY: SUPER-NURSE OR HUMAN BEING?**

The polarisation of roles into strong carer and dependent patient seems to make it difficult for some nurses to talk about their own needs at all. I repeatedly found that when I asked participants about their personal needs they slid away from the subject or answered in terms of what they need to fulfil their role as nurse. Several described their work in ways that suggested that they give so much of themselves to their work that there is nothing left. For example, Liz described what she aspired to as a nurse:

*totally* everyday reinforcing the fact that the patient was the most important thing on the ward (Liz: 193-194)

As well as being ‘totally’ there for the patients Liz claims that:

As a charge nurse I totally, totally was there all the time for the staff (Liz: 177-178).

I was left wondering how, or indeed if, Liz fitted her own needs into this framework. The accounts of other participants suggest that some do not. Elizabeth’s description of the personal impact of trying to maintain her high standards early in her career demonstrates the personal costs of giving in this way:

My husband would say our relationship suffered. He would just pick me up in pieces at the [end of a shift, and] on my days off I would *sleep*. I wasn’t much fun to be with because I just needed to sleep all the time and I just didn’t have it. It was just work and sleep because that’s how it was it was *so hard*. (Elizabeth: 125-129)

Christine’s reflections on aspiring to a high standard of work also indicate the personal cost of giving so much:

you always want to just go that extra mile and offer that bit extra but then that bit extra becomes standard and then you end up in the point that you’re so thin (unclear words) I don’t know. (Christine: 796-807)

Her account of this struggle conjures in my mind an image of a person stretched like a piece of rubber to the point where it becomes translucent and threatens to break. Even her voice diminishes to the point where it is difficult to hear her.

While Gemma shares Christine’s experience of struggling to meet the standards she has set herself; she has reached some kind of compromise that she expresses in a mathematical form:



I think before maybe I used to get that frustration but now I don't because I am experienced enough to know that 'OK I want to give you 150%, I can only give you 90%. I can't help that'. 'But if I gave you 150% I'd only be giving the person next door 50%', so you have to weigh it all up. I'd rather have ten people semi-satisfied than one person 100% satisfied, and that's something you have to live with (Gemma: 1296-1307)

Gemma's arithmetic certainly leaves something to be desired. She wants to give each person more than 100%, but sees the extra as detracting from that which she offers the next person, indicating that her percentages are cumulative and the resources she has available to give are finite. However, in giving ten patients 50% she is giving a total of 500% as opposed to giving one patient 100%. This may seem a ridiculously pedantic concern with what was not intended to be a serious calculation, but it points to the level of giving that nurses expect of themselves. A similar use of percentages appears in Karen's comments about the conflict between family and work commitments:

The staff give 110% every day they're at work and you can't expect any more from them. And particularly the staff I've got just now, quite a lot of them have got young children etc and they have got different priorities in their lives and they *do* give a lot when they're here. They just can't you know, give any more. (Karen: 351-362)

Although she seems to be arguing that it is not reasonable to expect nurses to give to their work at the expense of their families, Karen still sets the level of expectation at well over 100%. The mathematical analogy is also used by Judy to describe her experience of giving, stating that since she is giving 100% at work and 100% at home there isn't any space left for anything more (Judy: 639-643). In all of these examples the question arises, what is left for the nurse's own needs? In their mathematical equations these nurses evoke an image of a disappearing carer, who dishes out portions of herself to others until there is nothing left.

The tendency to identify so completely with the role of strong carer that a person does not attend to her own needs is a phenomenon that is not restricted to nursing. Rather, nursing can be seen as an example of a wider feminine discourse that appears in several contexts. The experience of emotive dissonance described by Hochschild resonates with van Scoyoc's claim that women, as mothers, spend so much time in meeting other people's needs that they can lose touch with their own needs and begin to feel invisible (van Scoyoc, 2000). She claims that:

When women become invisible to others in their roles as mothers they tend to lose themselves. (Van Scoyoc, 2000: 87).

The same sense of losing oneself appears in Hickman's study of diplomatic wives:

The loss of identity experienced by many spouses is 'about having to put on a false self, and perhaps becoming increasingly uncomfortable with it'. (Anonymous diplomatic wife cited by Hickman, 2000: 298)

The invisibility and loss of self experienced by these different groups of women is also a recurring theme in this study of nurses and has been noted by previous authors (e.g., Mackay, 1989). Nurses' own dominant discourse is of self-sacrifice in service, and, as I argued in chapter three, the industrial discourse of health care organisation presents them as interchangeable, faceless drones or pairs of hands rather than as whole people. Both discourses act against the recognition of nurses as real people with needs of their own. Nurses' experiences of invisibility and loss of self are compounded by a situation in which much of their work is also invisible unless it is done badly or left undone altogether (Davies, 1995; Graham, 1983). James argues that their emotional labour is rendered invisible by the masculine assumptions underpinning the organisation of work in which the expression and management of emotion are expected to be confined to the domestic sphere (James, 1989). An exploration of this phenomenon is beyond the scope of this study but it seems likely that nurses suffer in similar ways to people in other roles involving emotional labour and that this is an area that merits further study.

## **BEING A NURSE OUTSIDE OF WORK: CONFLICTING ROLES AND BLURRED BOUNDARIES**

In the issues raised above I focus on the problems caused by the lack of boundaries to the identity 'nurse'. However, the all-encompassing tendencies of the nursing identity mean that it can cross the boundary of the workplace to conflict with the other roles that a nurse plays in her personal life. When this occurs, role boundaries can become blurred, creating confusion as to exactly which role a person is performing and therefore how she should behave.

The widespread expectation that a nurse should make her skills available to anyone who needs them is reflected in the accounts of several participants (Barbara: 475-480; Judy: 611-628; Christine: 861-863; Karen: 901-935; Mark: 447-467; Robert;

421-433, 450-464). Some are happy to act as the nurse towards friends and family, offering advice and support as well as physical care (e.g. Jane: 447-473; Mary: 256-83), but others find the experience very unsettling. For example, Judy speaks of how she tries to avoid 'crossing the boundaries' and treating friends as patients (Judy: 624-628). Maria describes the blurring of work and personal roles as going into a 'nurse role' (Maria: 587) a label that points to the difficulties that nurses face in treading the tightrope of their professional boundaries. While there is an expectation that nurses should not withhold their care and knowledge from people in need simply because they are not at work (Barbara: 510-512), the combining of work and private roles can create problems. For example, Barbara describes how she attempted to care for her sick father but found that her closeness to him interfered with her ability to think clearly (Barbara: 518-527). Maria's reflections on caring for her father-in-law also point to the difficulties nurses face in such circumstances (Maria: 606-610). Providing physical care in the form of washing or toileting is something that cannot be easily reconciled with the taboos against intimate physical contact between adult family members. Although Maria's father-in-law died before reaching a point where such contact was required, the possibility of being faced with this situation caused her serious concern.

Eileen also describes the problems of blurring the boundaries between working and private roles. She tells the story of how, as a student, she attended a dance with a group of friends from her class. One of them told a young man with whom she was dancing that they were nurses, and she suddenly found herself listening to his experiences of having an ileostomy<sup>62</sup> (Eileen: 371-406). His response to finding out that she was a nurse meant that she could no longer relate to him simply as a young man with whom she could enjoy the evening. Her work had intruded into her social life making them nurse and patient instead of woman and man.

Although Eileen was extremely uncomfortable with this behaviour, she was willing to take on the 'nurse role' under more extreme circumstances when action was clearly needed:

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<sup>62</sup> An ileostomy is created during a surgical procedure in which the large intestine is cut at the level of the ileum. The upper portion is used to create an opening, or stoma, on the abdominal surface. The lower portion of the bowel is therefore bypassed, and faeces pass out through the stoma into a bag attached to the person's abdomen.

I was being driven by my brother-in-law and there was a few of us in the car and we came across ... it was an accident and a young lad had been knocked down by a bus and we'd got there *just* after it had happened and he said 'Do you want to stop?' and there was one of the other girls *used* to be a nurse and said 'Well we have to'. (Eileen: 350-355)

In this situation, there was no question in Eileen's mind that she had a duty of care to the injured person. Her role was clear and she describes switching into a different gear for the duration of the emergency (Eileen: 349). The difference between the two situations seems to centre not only on the nature of the demands made upon her, but upon the clear demarcation of roles. At the scene of the accident she was clearly a nurse and had no other relationship with the injured man, while at the dance she was faced with the blurring of roles as nurse and dance partner.

This blurring of roles highlights an inherent difficulty that nurses face in trying to balance a commitment to nursing with life as an ordinary person. In many occupations, having particular skills may prove to be an inconvenience when family and friends expect these skills to be placed at their disposal. A decorator may find herself painting a friend's house, or a driving instructor may face pressure to teach family members. However, as Maria shows, a nurse may find herself performing intimate tasks for friends and loved ones that break the normal rules of the relationship. Furthermore, while few people will expect a stranger who is a carpenter to provide a free service, Eileen's experience at the dance illustrates a widespread expectation that a nurse will listen to the most intimate details of a complete stranger's life. The clash between working and social roles has the potential to create serious difficulties and yet the discourse of total commitment makes it difficult for nurses to refuse to help.

While these examples relate to specific instances in which people find themselves combining their nursing role with that of family member or friend, the expansion of a nursing role into a person's private life can have more serious consequences. In his reflections on his relationship with his family, Mark indicates how becoming a nurse can lead to being identified within one's family as the 'strong one':

I still had that role in the family where I've been the one ... [I ask them] Oh, how you doing? and my sister's at various points said to me 'Well, nobody kind of asks you.' (Mark: 447-451)

For Mark, being a nurse does not just mean playing the role when his family need his skills. Instead, it seems to have become a part of the person that his family see when they look at him. In identifying him as a strong nurse they no longer recognise that he too has needs and might appreciate someone asking how he is. This response from a person's family is likely to reinforce his or her own identification with the role of super-nurse or, alternatively, may cut off a valuable source of support for someone who is willing to seek it. As such this is another potentially fruitful area for research.

## **CONCLUSIONS**

In this chapter I describe nursing as a role without boundaries, extending beyond the workplace to conflict with nurses' personal roles and even incorporating itself into their sense of self. This lack of boundaries poses serious problems both for nurses who internalise expectations of the super-nurse, for those who seek to retain a sense of themselves separate from their work, and for those who attempt to set protective limits to their giving. In denying the humanity of nurses this discourse opens the doors to exploitation and abuse of those who can no longer protect themselves, reduces the support available to those who are willing to accept it, and creates a situation in which many nurses are afraid to ask for help. The discourse of the super-nurse simultaneously adds to the burden carried by nurses whilst reducing the support that they need in order to bear it. This discourse of self-sacrifice and endurance adds to the problems that nurses encounter in relation to a workload without boundaries and a total commitment that pushes aside all others. In the next chapter I show how nurses survive in this context of conflict, challenge and impossible choices, and how those who choose to leave nursing behind reach this very difficult decision.

## **CHAPTER SIX**

### **Responding to Life on the Boundaries**

In previous chapters I showed that nursing is more than a role that a person plays in their place of work; it is understood as a demanding commitment that extends into a nurse's personal life, shaping her identity and often coming into conflict with her other roles and commitments. Nursing is an occupation characterised by a lack of clear boundaries, which requires its members to engage in complex negotiations in order to function both as nurses and as people. In many instances there are no 'right' choices, and nurses may face criticism or personal feelings of failure whatever they do. However, the lack of boundaries can also be experienced as a challenge, opening opportunities for nurses to expand their role and achieve greater autonomy at work, and to offer their skills and knowledge to family and friends.

Nursing can be both a source of great frustration and of satisfaction, making intense demands but also providing powerful personal rewards. In this chapter, I show how nurses respond to this challenging situation. I describe why some continue to enjoy their work while others find it too much to bear; why some stay and others leave. I begin by describing participants' perspectives on the costs and rewards of being a nurse, since a weighing up of the pros and cons forms the basis of nurses' response to the difficult situations in which they find themselves. I then describe a series of steps that nurses take in response to the stresses of work. In each case I show how some participants found in each step a solution to their difficulties, while others went on to take more serious measures. I also show how a few went so far as deciding to leave nursing completely. I argue that, contrary to popular opinion, leaving is a very difficult decision for nurses to make, and that it is usually a last resort when the person concerned has lost any hope of finding a way of making their working life bearable. Even then it is a process that can take some time as the person concerned tries to adjust to a life beyond nursing.

## WEIGHING UP THE COSTS AND REWARDS OF NURSING

As I argued in chapter two, categorising nurses according to their attitude towards their work is a difficult task since their feelings and responses fluctuate in response to a wide range of factors. Furthermore, a person may express an opinion without necessarily acting upon it. In stating that she would like to leave nursing, a nurse may be expressing a definite intention, a persistent feeling upon which she does not intend to act, or simply the response to a bad day at work. Gemma demonstrates the complex and changing nature of nurses' feelings towards their work:

I see nursing sometimes very negatively and other times I see it very positively. And when I'm going through a negative stage I think 'God I wish I had gone and done something else'. I think, because I have studied for so long, I mean I have studied nursing since 1989, and I've never stopped studying, and I think 'well where has it got me?' and I know my job is quite a good job but I think, 'Where am I gonnae go now? I'm a G grade now but what next?'. I mean an H grade is not gonnae give me much return financially and I think 'Why have I studied this hard for so long?' To be in an organisation where there are so many constraints you haven't got the ability to go on. And that's my negative days and I think 'God I wish I'd just gone and done something else'. And then I speak to other people that are in other professions and I don't think that there's any profession that's easy, so I think 'Oh well fair enough I'm here and I'll just make the most of it.' (Gemma: 184-197)

Gemma demonstrates how nurses weigh up the costs and rewards of their chosen occupation when deciding how to respond to a period of unhappiness or dissatisfaction. For Gemma, the balance seems to be more against nursing, but the costs of leaving, and the possibility of finding anything better, are too low for her to choose this option at present.

The balance between the rewards and costs of nursing is not simply a matter of a conscious judgement by nurses deciding how to respond to the problems they face. Bakker et al (2000) claim that an imbalance can lead to burnout among nurses who consistently put more into their work than they receive in return. Furthermore, they claim that nurses who 'put a relatively high intrinsic effort into their jobs', i.e. those who invest more of themselves in their work, are at the greatest risk in this respect (ibid.). This is an important consideration with regards to those nurses who feel unable to either change such a situation or to remove them from it, as I argue below. In this section I demonstrate how nurses' responses to dissatisfaction reflect

a complex weighing up of the intrinsic and the extrinsic costs and rewards of nursing as well as those of other potential options.

### **THE PERSONAL COSTS AND REWARDS OF NURSING**

In previous chapters I focused largely on the demands that nursing makes on its members and consequently on the costs. Participants speak of their frustration, their fear and anger; of the intense physical and emotional demands made upon them both by their work and by the need to juggle nursing with other commitments. They describe an occupation that can create high levels of anxiety without offering commensurate levels of support, and that can dehumanise and exploit its members. However, one cannot understand nurses' responses to these costs without considering the powerful rewards that nursing can offer.

Throughout the interviews I was struck by the enthusiasm shown by participants for nursing. Christine's enthusiasm as a student was such that she describes it as being 'beyond belief' (Christine: 276).

Och [I] *loved* my training. I used to jump out of bed at ridiculous times in the morning and get all excited about coming to work. And I still am now. I do just love nursing. (Christine: 226-228)

Gemma (1184-1186), Karen (649-661), Lindsay (551-553, 732-743), Lesley (871), and Claire (620-621) all speak of their love, or even passion, for the work, and nursing is clearly much more than a job for all of these people. Anne, who describes herself as having a vocation, defines this as 'A burning desire to do the nursing.' (Anne: 880). These nurses have not simply decided to accept the commitment that is expected of them as nurses, they feel it as an emotional attachment that shapes their willingness to leave when the costs of being a nurse seem too heavy to bear. Why is it that these people have developed such strong positive feelings about an occupation that demands so much from them? Two possible answers can be found in their accounts of being a nurse: first, the way in which nursing meets deep personal needs in its members, giving a sense of belonging and fit; second, the powerful nature of the personal rewards that can be gained when working closely in a helping relationship.



## **A Sense of Belonging**

For several participants, one of the most rewarding aspects of being a nurse is the sense of having a place in the world. In chapter five I argued that nursing carries a certain degree of status in British society, and several participants speak of the satisfaction they receive from knowing that they are doing a 'worthwhile job' (Margaret: 121-129; David, 173-174; Mark: 300). For Liz, becoming a nurse and 'being one of the girls' was an important achievement since, as a child, she had always thought of nurses as a glamorous group to which she aspired to belong (Liz: 358-362). In moving to management she feels the loss of this sense of belonging keenly. For Emma, moving from clinical nursing to management also involved a sense of loss, in this case the loss was of a role that conferred a certain degree of status on her and that other people understood easily (Emma: 568-579).

The sense of having a place and belonging also relates to participants' experiences of being part of a team. As I showed in chapter three, effective nursing depends to some extent upon the smooth functioning of a team of nurses. Working closely together, often in stressful circumstances, can create strong bonds that last long after people have ceased being members of the same team. For example, Maria has kept in touch with colleagues from previous wards (245-261), and Elizabeth describes 'life long friends', made while she was in training, who have provided a vital source of support (Elizabeth: 381-389). Emma also continues to spend time with friends made during training (Emma: 66-67).

Being part of a good team involves an important sense of being 'in the same boat' (Maria: 246) and although seeking help as an individual may not be an option, the camaraderie, and what Jane describes as 'debriefing' after a shift, can help nurses through difficult times (Jane: 356-364; Lynch, 2002) as well as providing the opportunity to forge strong friendships. For those participants who have left nursing, or are planning to do so, being part of a team is one of the main aspects of nursing that they miss or anticipate missing. For example, James speaks of missing the camaraderie (239-243) and, as a manager, Emma also misses being part of a team (Emma: 550-551). Both Jane and Margaret anticipate missing the closeness with their colleagues and the sense of belonging when they leave (Jane: 751-760; Margaret: 622-623). Although Christine was only away from nursing for a few

weeks during maternity leave, her colleagues' response when she returned, and the sense of being needed by them was gratifying:

All my colleagues are saying 'God its great to have you back. We've missed having you around. We've missed having your input', and that kind of thing. (Christine: 523-551)

In cases where teamwork breaks down due to the pressures of work or the instability of the team, nurses lose these valuable rewards. The fostering of team bonds is therefore an important consideration for those seeking to persuade nurses to continuing practising.

### **A Sense of Fit**

The sense of a fit between the nurse and her work is a recurring theme in participants' explorations of what it means to be a nurse. They speak of how nursing either is, or has been, somehow 'right' for them. For example, David speaks of how nursing fits his personality (David: 176-179), and both Elizabeth (107-114) and Jean had a similar experience before leaving nursing:

I really found my niche. I mean district nursing was for me definitely and I loved it, absolutely loved it (Jean: 67-69).

For Emma, whose father opposed her choice of nursing as a 'thankless job', her choice of career is a matter of 'horses for courses' (Emma: 112). She illustrates this point with an account of a conversation that she had with a policeman when working in Accident and Emergency. She told him that she couldn't do his job 'for a pension', to which he replied that he felt the same way about nursing (Emma: 107-112). Each felt at home in their own field and could not contemplate the other's choice. For Emma, the order and routine of hospital nursing reflect her experience of a highly 'structured' and 'regimented' childhood (Emma: 119).

I like routine, I like order. I can cope with having to change priorities and move things around but I like sticking to a schedule and I think pretty much in hospital I think that's what there is. It's a schedule. It's a schedule of theatre lists and outpatient appointments and all these sorts of things. (Emma: 305-308)

In nursing, Emma has found a field of work that makes her feel secure and comfortable. Although neither the policeman nor her father could understand her choice, the fit between Emma's personality and her work provides her with a great

deal of satisfaction and, for her, nursing is far from being a 'thankless job'. For some nurses, nursing provides such a strong sense of fit that they find it difficult to contemplate the idea of being anything other than a nurse. Barbara suggests that, for her, becoming a district nurse might have been a matter of 'destiny' (Barbara: 454), and both Liz and Mary describe nursing as being 'in your blood' (Liz: 521; Mary: 637-639).

In contrast with the idea of being called to nurse by the controlling forces of genetics or destiny, Valerie's and Mark's reflections, cited in chapter five, suggest that for some, nursing fulfils deep personal needs originating in childhood. If this is indeed the case, it is easy to see how such people come to be so deeply committed to their work, and why they may be prepared to sacrifice their own personal lives in the name of that commitment. Whether the origin of a feeling of fit is ascribed to genetics or to past experiences, the presence of such strong feelings suggests that, for some nurses, leaving is a very difficult option to contemplate. However, not every nurse feels the need to be needed or has a history of caring for others that shapes her choice of career. For many, feelings of commitment are associated with a belief that no other job could possibly match the rewards that nursing offers (e.g. Gemma: 1254-1263; Mackay, 1989: 33).

### **Extreme Situations Offer Extreme Rewards**

Given the often daily frustrations and difficulties that participants speak of, at times it is hard to see why they retain such a passion for their work. From a lay perspective, it might appear that the anxiety inherent to nursing contributes to nurses' dissatisfaction with their work and their desire to leave. Who wouldn't become stressed in a job that involves dirty, menial work and frequent contact with disease, suffering and death? Indeed, when I began this study, many friends and acquaintances laughed at the idea of studying why nurses leave because, to them, it seemed self evident that nursing is an extremely stressful job for which people receive little recompense. However, as I listened to participants' stories of events that summed up nursing for them, I was struck by how many immediately thought of incidents in which they had cared for patients who died. It seems that the worse the scenario, the greater the rewards, providing that nurses are able to offer the care that they deem necessary. Thus, for Valerie, daring to break the rules by

disconnecting the machinery that dehumanised a dying child, and restoring her to her mother's arms as she died, was one of the most intensely meaningful moments of her career.

I think that's probably one of the most special times, just to be able to sit with her and make her a little girl again before she died rather than this thing that you could hardly see in the bed, for all the gadgets. Yeah, I think there's a *hundred* [examples] but that was when I was the happiest, early in nursing, and thought 'This is what it's about.' (Valerie: 1008-1011).

Eileen also reflects this association between tragedy and a deep sense of satisfaction in a story that goes from bad to worse. She begins by describing how she and a colleague were present at the death of a young woman who had not told her parents of her terminal condition. Having cared for this woman in her last moments, and comforted her distraught parents, they went on to their next visit:

It was just before Christmas and I was going straight on after that to sit with a couple whose daughter had died as well, and whose funeral it was that day, but they couldn't go because the mother was disabled, and he didn't want to go, but they had other members of the family that had gone. (Eileen: 997-1001)

At this point I began to wonder how much worse their situation could get. Each patient's story was a tragedy in itself but the combination of the two began to take on the unbelievable intensity of a TV drama, except that this was a real situation with which these nurses had been required to deal. I wondered what it was about these situations that led Valerie and Eileen to offer them as examples of what nursing is all about. For Eileen, the sadness and anxiety she felt seem to have been balanced by an enormous satisfaction in the fact that she and her colleague had been able to give time to these families and make a dreadful situation a little better:

I just thought 'We're seeing these people through these terrible times' and we could *give* the time to do that. It didn't matter how long we stayed there with Sarah's parents and with her, and it didn't matter how long I stayed with this elderly couple that I was then going on next to. It was this sudden appreciation that our time could stop with that patient. We didn't have to rush off to the next bed [and] sort of think 'Oh, I've got a drug round to do'. The rest of the morning, or the day, could just progress later on. We were needed at that point and it was really quite nice to be able to look back and think 'Yes, I gave them the time that they needed'. (Eileen: 1001-1011)

Not only does Eileen refer to the fact that she was needed, a feeling that, as I have already shown, is a powerful motivator for some nurses. She was able to give that family exactly what *they* needed. Her satisfaction appears to have come from her ability to give something really valuable. For Valerie, a similar situation existed. She was able to give a child back to her mother in the moments before death. In her case, the gift was even more precious and powerful in that she restored the child's humanity as well as offering comfort to the mother. The ability to offer other people such gifts seems to provide these nurses with enormous personal rewards in return.

Heather and Claire, who speak of times when intense situations created a bond between them and their patients, also illustrate the powerful rewards that extreme situations can offer. Heather explains how being present when a patient is told of a serious diagnosis leads to a situation in which the people involved are no longer a nurse and a patient, but 'my nurse' and 'my patient' (Heather: 77-88). She also describes how, nine years after caring for one particular woman, she still remembers her name and date of birth, having checked her details so often when administering morphine (Heather: 85). Claire's description of a meeting with an ex-patient in her local supermarket demonstrates how patients too remember their 'special' nurse long after they have been discharged.

He told me he'd been a patient in my ward and he said he'd been unwell, really unwell, and I said 'Gosh, you did well to remember', because it was a number of years ago, and he said to me 'I would never forget you, I always remember.' He said 'I saw you and I didn't know whether to come over.' So I said to him, 'I'm glad you did' and I asked him how he was and he said that life was grand and I felt that inside me again, that very pleasing element (Claire: 409-416)

For all of these nurses, an extreme situation produced an extreme reward: the power to offer humanity, to offer one's time and support to people in desperate need, and the feeling of being very special to another person. When one looks at participants' stories in this light, it is easier to understand why so many nurses continue to nurse, even when, for the most part, their experience is one of frustration and unrelenting hard physical labour. Participants' accounts lend support to Adams' claim that patients are an important source of creative energy for nurses and offer a means by which they can achieve renewal, commitment and growth leading to a greater capacity for dealing with stress (Adams, 1984). When

nursing becomes unbearable, it seems likely that these kinds of experiences can act as a motivator, even when the intense rewards they offer are few and far between. A nurse is also likely to ask herself: Will I find this kind of satisfaction in any other kind of work? In the light of the powerful rewards that nursing offers, the strong sense of commitment that many nurses experience seems less surprising. These feelings fit well in a culture that stresses commitment, and provide an important counterbalance to the heavy weight of duty, self-sacrifice and discipline that nurses are expected to bear.

## THE FINANCIAL COSTS AND REWARDS OF NURSING

### The Complexity of Nurses' Attitudes Towards Pay

Table Two, Nurses' Pay Scales<sup>63</sup>

Grade	Lowest Increment	Highest Increment	Highest Increment Plus Discretionary Awards
D	£16,525	£18,240	-
E	£17,660	£21,325	-
F	£19,585	£24,455	£25,360
G	£23,110	£27,190	£28,125

(Based on figures from RCN, 2003b)

In response to problems with recruitment, wastage and nursing shortages in the NHS, both policy makers, and those who represent nurses, tend to focus their attention upon the issue of pay (Buchan, 1997). The assumption seems to be that nurses who are thinking of leaving will change their minds in response to a wage increase (RCN, 1999b), and that higher wages will make nursing a more attractive option to potential recruits (Vousden, 1998: 18-19; Colwell and McFarlane, 2000;

<sup>63</sup> These figures relate to pay scales for the grading system in place when the interviews for this study were conducted. They therefore reflect participants' relative incomes. Since that time, *Agenda for Change* has replaced this system with a new pay and grading structure. More recent figures cannot therefore be directly related to participants' accounts.

*Nursing Standard*, 2000a). This may indeed be the case, since an RCN survey has found that 88% of E grade staff nurses believe that a pay rise would encourage them to stay in nursing, and 45% say that it is the single most important factor in whether or not they decide to stay (RCN, 1999a). However, Meadows et al claim that most of the nurses in their study, if given the choice, would prefer extra posts in their workplace to wage increases (Meadows et al, 2000). Some participants' attitudes towards wage increases also indicate that nurses' responses to such policies are more complex than the RCN survey would suggest. For example, Frances sees attempts to solve recruitment and retention problems, by giving selective wage increases, as actually creating further problems:

There was no real motivation by that time to have the charge nurse post, the F grade post. So E grades who had been qualified four or five years were actually earning *more* than the Fs and G grades who were confined to the 8-4s (Frances: 38-41)

F and G grade nurses (the two most senior levels on a ward) are only permitted to work 8am–4pm shifts in the Trust that Frances is referring to. In being confined to daytime shifts, senior grades lose the opportunity to earn extra payments for working unsociable hours. This, combined with selective wage increases targeted at E grades, can result in F and G grade nurses earning less than their junior colleagues. Direct experience of this phenomenon led one nurse to write to the Prime Minister threatening to leave because she found herself earning less than her junior colleagues (*Nursing Times*, 2000b). Although several of the participants in this study are unhappy at the level of nurses' pay, none are leaving simply because the pay is inadequate. As a graduate nurse, Jane points to the low wage ceiling that nursing imposes upon her but appears to be more concerned with the limitations on her practice (Jane: 525-536). Lesley (481-484), Elizabeth (510-527), Jean (655-656) and Margaret (569-571) all complain that nurses do not receive sufficient money to compensate them either for the level of responsibility they carry or the stress involved in nursing. However, money plays only a minor role in the decision that they have all made to leave nursing. For Mark, who left the financial security of nursing to spend four years on a student grant retraining as a social worker, the question of inadequate pay simply does not arise. People who could not understand his decision to leave asked if he would return to nursing at the end of his course:

Well I just laughed at them. I thought 'Well why would I do that? If I was going to sacrifice so much for four years, why would I want to go back to that?' (Mark: 970-972)

Jean's actions also indicate how low on her list of grievances pay is in that she is now working in a job that she describes as paying much less than district nursing, but giving her greater satisfaction (Jean: 378-379). Her frustration with nursing is such that:

They could have the best childcare, they could have the highest pay and it's not gonnae get me back in (Jean: 1248-1250)

Lesley shares Jean's frustration, claiming that 'nothing would entice me to go back' (Lesley: 812-813). The position taken by Jean and Lesley is not unusual and is shared by the author of a letter written to the *Nursing Standard* entitled 'No Amount of Pay Could Compensate for Stress' (Batty, 2000). For Liz, in focusing on wages, the RCN is 'totally missing the point' (Liz: 703). Although she describes nurses' wages as 'a pittance' (Liz: 494-495), as I showed in chapter five, both she and Sue believe that the real issue is their inability to care holistically for their patients. This is a problem, which is as much about the organisation of nurses' work, as it is about staffing shortages.

While the participants cited above express unhappiness at the level of nurses' pay, others are content with the wages that they receive. For example, Christine, as a G grade specialist nurse, believes that she is 'well paid' for her work (Christine: 866-871), a position that she shares with Robert, a G Grade health visitor (716-719). For Karen, being happy and satisfied at work is more important than money, a position that some of her friends seem to find strange:

I *value* my work and I think they think it's surprising that I would give so much to what they perceive as being so little in return. I think that's probably the biggest thing, whereas my husband's a software development contractor so he makes about four times the amount I do, and *he* admits to going to work and not doing a *tenth* of the things I do, and he gets paid four times the amount per *hour*. I think people can't believe one would do that for no financial *gain*, or not a tremendous financial gain which I don't really think's got anything to do with it because if I say to my husband 'Well do you really enjoy your work?' he'll say 'Mmm no.', whereas if you ask me I'll say 'Yeah, on the whole, when I think about it in a *big* picture I do, I really *love* my work most of the time. (Karen: 636-647)

In reflecting on the relative importance of happiness and money, Karen inadvertently identifies an important issue influencing nurses' attitudes towards



their pay. As the wife of a man who brings in a substantial salary, Karen can afford to focus on the less material benefits of her work. For others, money is much more pressing issue that cannot be ignored.

### **When Money Matters**

While difficulties in fulfilling their financial commitments may not be the key reason for leaving nursing, money is clearly an important consideration for many nurses. For example, Ball and Stock claim that 28% of respondents to the 2000 RCN membership survey had a second job, and that 84% of these nurses did so in order to supplement their income (Ball and Stock, 2000: 24). These figures have remained relatively stable with 27% of respondents to the 2005 survey holding an extra job, and 72% of these doing so in order to provide extra income (Ball and Pike, 2005: 24). These extra jobs contributed to a situation in 2000 in which, full time nurses worked an average of 52 hours per week, while part time nurses worked on average 37 hours a week. (Ball and Stock, 2000: 25). The majority of these nurses worked for a nursing bank or agency (ibid.). Again, there has been little variation in this pattern of hours since 2000 (Ball and Pike, 2005) and, as I showed in chapter one, there has been a further shift towards agency and bank work.

As a staff nurse I was often asked by my managers to work a double shift at short notice, and pressure was placed on myself and my colleagues to join the hospital bank. I refused since I did not need the money enough to work through from two in the afternoon until seven the next morning, but many of my colleagues chose to do so. Working extra shifts in this way, and combining multiple jobs, must have implications in terms of nurses' levels of fatigue, and their ability to function effectively.

The important role that money plays in nurses' decisions regarding their careers is apparent in the accounts of several participants. Claire has spent most of her working life on night duty, trying to support two children on a single income. Anne's career has also been shaped by the need to work in order to support her family. When her children were small, she had to work part time night shifts, and when her husband was made redundant she was forced to return to full time work

to keep a roof over her family's head (Anne: 36-41). Despite loving her work, Anne resented her situation:

When I went full time on night duty, after having only done the two nights, I *resented* having to do that. I felt that my life was being ruled by what was happening in *our* life. I had to go to work to make ends meet and I remember feeling very resentful, not for the job, because that was never a problem, it was the fact that I had to do it *all the time*, instead of choosing when I did. (Anne: 617-623)

Anne is not the only participant who has found herself as the main breadwinner in the family. Maria speaks of having to work to support her husband who is unable to work due to injury (Maria: 720-733), and Lindsay continued to battle on in her job as a theatre nurse, even though she was miserable, largely because she could not afford to leave, even though her husband also worked (Lindsay: 679-681). Although David enjoys his work, he recognises that he has to continue nursing in order to pay his mortgage (David: 168-171), while Gemma, and Sue also speak of the need to work in order to live (Gemma: 389-401; Sue: 546-547). Whether or not these nurses enjoy their work, and are committed to it on a personal level, nursing is a vital source of income. They cannot afford to ignore the level of financial rewards that nursing offers in favour of the personal satisfaction to be gained.

These examples point to two key factors shaping nurses' attitudes towards money; first their stage in the life cycle, and second, their class background. In combination, these two factors largely determine a nurse's attitude towards the financial rewards of nursing, and the options that are available should she wish to leave. For single nurses like Liz, Emma and Mary, it is perfectly possible to live on a nurse's wage, particularly when one reaches the level of charge nurse or manager. For married women with no children, a nursing income, when combined with a second salary, can also allow a comfortable lifestyle. However, with children and a mortgage, life on a nurse's salary can become much more difficult. Indeed, many nurses are finding that they cannot afford a mortgage at all and have been priced out of the housing market altogether (RCN, 2005d; Mower, 2005). As both Barbara and David note, many of those who do hold a mortgage have reached a point in their careers where it would be extremely difficult to leave nursing and earn enough to maintain their repayments.

You think 'Retrain at forty?' and it just didn't seem feasible and financially viable because by that point I had a mortgage that

reflected the income I was earning in nursing, and I knew there was no job I could walk into that would [offer the same level of income]. Nursing isn't *that* well paid but as a Sister it's better than some, and certainly not a starting wage in *any* job (Barbara: 795-800)

For Barbara, life as a nurse became so intolerable that she eventually decided to sell everything she owned and go travelling while she considered what to do next (Barbara: 723-727). Barbara was able to take this drastic measure because she had no dependants. However, for nurses like David, with a family and a mortgage, this is not a viable option. When Lesley felt the need to leave nursing, the fact that she had no children, and that her husband earned enough to cover the financial risk involved, meant that she could follow her dream of setting up her own business (Lesley: 457-458). In contrast, when Lindsay found her working situation intolerable, and wanted to retrain as a horticulturist, her responsibilities as a mother, and the impossibility of sustaining the family on one wage, prevented her from doing so (Lindsay: 679-681). Gemma also says that there have been times when, if money hadn't been 'an issue', she would have left nursing (Gemma: 633-636).

In previous generations it has been possible for nurses to live in hospital accommodation throughout their working lives. However, nursing home accommodation is no longer an option for qualified staff. Many nurses now find themselves in a situation where they struggle to meet their financial commitments to a mortgage, to rented accommodation, or even to the basic necessity of feeding and clothing themselves and their dependants. The cost of living in the South East of England and London is now so high that prefabricated homes have been constructed in order to accommodate the people who provide essential services, like nurses and teachers, who cannot otherwise afford to work in these areas (BBC, 2002c). In these more expensive parts of Britain, the high cost of living contributes to employers' difficulties in recruiting nurses as much as a shortage of nurses *per se*. The extent of these problems is indicated by the appointment of a NHS housing co-ordinator with the remit of finding solutions to the lack of affordable housing for NHS staff (Mulholland, 2002b). Other attempts to assist NHS staff who cannot afford accommodation include the Starter Home Initiative that offers interest free loans of up to £10,000 to enable staff to buy their first home. This was launched in

September 2001 (BBC, 2002d), but has had limited success due to the mismatch between the funding available and the demand for assistance (RCN, 2005d).

Difficulties in meeting one's financial commitments on a nurse's salary are not confined to England. For example, Sue, who lives and works in Scotland, makes the connection between nurses' financial situation and their decision to leave nursing:

I think in the end they don't really want to leave. It's just that the financial rewards aren't always commensurate with the amount of work that they have to do, or the opportunity that they could have, and I see that the D and E grades particularly, some people are *not* going to move beyond those grades and for *them* the rewards are limited I think. And financially, if you live in an expensive town then how do you keep going? I can quite see why people change direction or do something different (Sue: 541-548)

For those nurses who are not lucky enough to live in relatively inexpensive areas, or who do not have a partner who brings in a substantial wage, a complete commitment to nursing that takes priority over everything else in their lives is a luxury that they may not be able to afford. However, none of the participants in this study left nursing for these reasons. Indeed, as I have shown in the cases of Lindsay, Maria, Gemma and Anne, a financial commitment to their dependants was the reason they gave for staying in nursing. This does not mean that other nurses have not left for financial reasons, but the absence of this particular motivation from this study suggests that the idea of inadequate pay as a reason for leaving needs to be treated with caution.

### **Differing Perspectives on What Constitutes a 'Good Wage'**

Nurses' attitudes towards pay are not only determined by the need to provide for their families. A person's perception of what constitutes a reasonable wage also reflects the expectations that they have developed in response to their class background and level of education. Since nurses are drawn from a wide range of class backgrounds, their perspectives vary. For example, Mark's large, working class family saw his E grade salary as excellent, and could not understand why he would choose to give it up to become a student on less than half the income (Mark: 863-866). In contrast, Gemma's experience is of being told, 'If you ever want to earn money, don't go into that profession' (Gemma: 105-106). Both she and Jane, as

university graduates, are aware that they could have earned far more had they pursued a different degree (Jane: 533-537; Gemma: 168-172).

Money also has a symbolic value, providing an indicator of the value to society of both the individual and the occupational group to which they belong. As Margaret shows, pay can be seen as a means of compensating nurses for difficulties that they face at work:

We've been paid better. I mean since the twelve percent pay rise it's much better but no, we should be paid at least twenty grand a year, you know for the *shit* we have to put up with and deal with and cope with. (Margaret: 568-571)

Elizabeth also refers to this symbolic value of money when she questions why she should be expected to endure so much stress for so little money (Elizabeth: 520-522).

Pay can also be seen as symbolic of the level and skill and knowledge that a worker possesses. For example, Kate points to the disparity between talk of a graduate profession and levels of pay, questioning how nursing can expect to attract recruits at this level if they offer so little financial reward<sup>64</sup> (Kate: 430-440). Her reflections on pay also show how it is symbolic of the level of respect that an occupation commands. For Kate, an increase in pay is not crucial to her family's survival since she states that, as the mother of a small child, she did not return to work for financial reasons (Kate: 563-573). Like Liz, her concern is more with the disparity between her own salary and that of a teacher or police woman<sup>65</sup> (Kate: 840-844; Liz: 493-495), groups with which nurses have traditionally compared themselves (Mackay, 1989: 32; Kiger, 1992: 203; Eley, 2002). For Kate, poor pay is indicative of the lack of respect accorded to nurses and, as such, is intensely frustrating and degrading.

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<sup>64</sup> A newly qualified nurse starts her career as a D grade staff nurse whether she has completed a diploma or an undergraduate degree.

<sup>65</sup> In 2003 a teacher's starting salary was £18,105, rising to £26,460 on the main scale (NUT, 2003). This compared with a starting salary for trained nurses of £16,525 (RCN, 2003b). At the start of her six-month training, a new recruit to the police force received £18,135, rising to £28,464 on the main scale (Police UK, 2003). These figures compare with the means tested bursary for diploma level student nurses of £5,432 (RCN, 2003c) and for undergraduate student nurses of £2,115 plus a maximum student loan of £1,960 (SAAS, 2003).

## **A Discourse of Working Without Expecting Rewards**

While the examples cited above draw on participants' desire for greater financial rewards, pay also has a symbolic function that can work in the opposite direction, creating a reluctance among some nurses to ask for, or accept, the need for any increase in their salary. The strand of nursing discourse that emphasises commitment also stresses the importance of wanting to care for others simply for the satisfaction to be gained in doing an important job. This position can be seen in Campbell's definition of a vocation as the use of God's gifts in the practice of a skilled profession (Campbell, 1984). The use of these gifts provides a sense of fulfilment and expressing oneself in helping others. He states that in this way:

professional care becomes a response to gifts, an act of gratitude, which has its own reward, rather than an act of grudging labour seeking some other satisfaction. (ibid.: 107).

The consequence of this emphasis on the intrinsic rewards of caring can be that a nurse who voices the need or desire for greater financial remuneration risks being labelled as a 'bad nurse'. In the past such associations were often made explicit. For example, Ethel Bedford Fenwick, a key figure in the campaign for nurse registration in the early twentieth-century, argued that high pay might attract the wrong type of recruit (cited by Peelo et al, 1996), an argument that was also used by the RCN after World War Two to oppose wage increases for student nurses (Carpenter, 1977). Such attitudes seem to be less common today, but Mackay reports that several nurses in her study expressed this concern with regard to pay rises (Mackay, 1989). A reluctance to be seen as focusing on financial rewards can also be detected in the position taken by some participants in this study, that other nurses deserve an increase but for themselves they are quite content. For example, Margaret's comment that 'money doesn't mean a lot to me' (Margaret: 158-159) contrasts with her claim that nurses should be paid at least £20,000 a year (ibid.: 568-571). While Lindsay claims that 'money's not everything', the financial constraints on leaving a job that was making her miserable indicate that money is more important to her than this statement implies (Lindsay: 759).

In some cases, this attitude towards financial rewards extends to cover the personal rewards of nursing too. In most cases, participants speak warmly about the personal rewards of nursing, often emphasising these over the importance of pay. However, some take a different position, apparently rejecting any form of personal

reward. For example, Anne speaks of being 'selfish' for enjoying the satisfaction of caring for others (Anne: 585). She asks, 'are you doing it for yourself or are you doing it for the patient?' (Anne: 590-591). Elizabeth voices the same concern saying, 'if you can help anybody then that makes you feel (...) um I don't know ... that's very selfish isn't it?' (Elizabeth: 500-502). Liz uses the same word to describe nursing as a whole:

Well I think nursing's quite a *selfish* profession as well in that you're often told how wonderful you are, how kind you are, that people do generally appreciate what you do, and it's quite an indulgent profession, it *can* be (Liz: 810-812)

For these participants, it appears that any positive return from their work is viewed with suspicion, as potentially undermining their commitment to a life of self-sacrifice.

The discourse of nursing as a special occupation requiring a deep commitment, and a corresponding emphasis on the inherent, rather than the financial, rewards of caring leads to a situation in which many nurses are ambivalent about the issue of pay. To discount the importance of pay on the grounds that some nurses are happy with their current salary is to deny both the difficulties, which their less secure colleagues face, and the symbolic role that money plays in modern, western society. However, to see improved pay as a panacea for the ills of NHS nursing is to overplay the role of money in nurses' decisions to leave, whilst ignoring the fundamental issues surrounding the organisation of nurses' work. The situation has been summarised by the Scottish Office:

Reward is of course not just about pay; it is much more than this. It is about other benefits, and a feeling of being valued and the ability to do a worthwhile job well. (Scottish Office, 1998: 54).

The importance of feeling valued was highlighted in the 2003 RCN membership survey, *Valued Equally*. Although respondents reported high levels of feeling valued by patients, 40% reported that their employers value their work 'a little' and 17% 'not at all' while 52% did not feel at all valued by politicians (RCN, 2003e: 71).

## **NURSES' RESPONSES TO LIFE ON THE BOUNDARIES**

As I showed above, although the costs of becoming a nurse are often high, it can also be a rewarding choice of occupation that offers intense satisfaction and a sense of belonging. These rewards act as powerful incentives to remain within nursing despite the more negative aspects of the job. Given the way in which nursing often becomes an integral part of its members' lives and sense of identity, one might expect that leaving is not a choice that most nurses make lightly. Indeed, this is born out by participants' reflections on leaving as one of a number of possible responses to unhappiness in their work. In this section I describe a range of responses to stress and dissatisfaction seen in participants' accounts of their lives as nurses. These can be seen as a series of steps reflecting the seriousness of the nurse's situation and her perspective on the acceptability or possibility of each option. Some participants have moved through all of these stages to the final measure of leaving while others have either found answers in, or been unable to move beyond, less drastic measures.

### **FINDING A WAY TO REMAIN IN NURSING**

#### **Learning to Cope**

For those students who do not leave at an early stage of their training, one of the most important lessons to learn is how to move from the panic of the 'headless chicken' (Barbara: 220) to the apparent calm control of the swan (Barbara: 238). Despite the discourse of the 'born nurse', a strong degree of self-control is not always seen as an innate personality trait. Rather, participants describe how they learned the necessary skills that allowed them to make this transition. Margaret (244-254), Maria (177-181, 190-200), Gemma (460-475) and Elizabeth (194-201) all speak of their early struggle to remain calm under the pressure of work and how they gradually learned to cope. Part of the issue for those who describe their student experiences is that of confidence. As Benner (1984) describes in her study of nurse education, as students learn and become more skilled they develop confidence and no longer need to think about every detail of their work, an achievement that reduces the stress that they experience.



In addition to developing a general confidence and expertise, participants' accounts suggest that they learn essential coping skills. In many cases these enable nurses to cope with the day-to-day stresses of their work. Sometimes, a nurse may only have to cope with a brief period of stress associated with a particular incident or a demanding shift before her situation becomes easier. However, as several participants describe, nurses are often expected to cope with high levels of stress over much longer periods. In such situations coping skills are very important. As Frances notes, it is sometimes easiest to take the path of least resistance focusing on coping in the short term, than to speak out and ask for help:

one thing that I have recognised is that you get through things, it will be OK in a few months and what you have to do is find a way to get yourself through the next three shifts (Frances: 797-799)

In so doing, Frances managed to cope with a very stressful situation in which she tried to protect both a colleague, whose work was poor, and the patients who were endangered by the situation. In this she was motivated by a feeling of team solidarity and the fear of being labelled as someone who 'tells tales' (Frances: 518-536) and in so doing she added significantly to her own workload. However, Frances finally reached a point at which she realised that it was not appropriate to focus on coping and something had to change for the good of all concerned (Frances: 535-618). She was able to go to a senior colleague for help and her situation was resolved. However, Frances' situation reflected more on the failures of another nurse than on her own inability to cope. As I have shown, in situations where nurses struggle to cope with their workload, or with a particular patient's care, they do not always feel able to ask for help. Some continue in their attempts to cope until the situation is resolved or until external factors intervene. For example, Elizabeth continued working in an extremely unhappy situation until a change in her husband's job gave her a reason to leave for a new post in a different city. Ruth became too ill to continue working, and Mary and I were both sent home by colleagues who recognised that we were not fit to work. In each case, those concerned waited until another person judged that they were unfit for work rather than taking the more assertive position of making that judgement themselves.

## Seeking Support in the Workplace

In apparent contradiction to the dominant discourse of individual strength and coping, several participants describe experiences of working in very supportive environments in which they feel able to acknowledge their struggles and to ask for help (Barbara: 338-643; Judy: 330-385; Jean: 449-452). For example, Eileen describes her present workplace as being a particularly supportive environment.

I think it is because it is a community setting. It's a totally different area of nursing and if you are in *good base*, which I am lucky enough to be, and I know all bases aren't like that, but yes, you can feel that you can say 'I can't *do* this any more. Can someone else take this person?' and no one's going to think any less of you (Eileen: 174-182).

Most of the examples of supportive workplaces come from community settings. It may be that the greater stability among some community nursing teams creates greater trust between team members, enabling them to ask for and receive support. Alternatively, the self-selection of district nurses, who choose this speciality because of the continuity of patient contact it offers, may explain the difference from hospital nursing. The nature of this study does not allow me to draw any generalisable conclusions from this observation but among the participants interviewed there seem to be striking differences in both attitude and experience between the two settings.

Despite the prevalence of community settings in the more positive accounts of workplaces there are also examples from the hospital setting. In chapter three I cited Christine's decision to hold staff meetings in her own home and, as a charge nurse, Liz explicitly established rules for her nursing staff based on mutual respect and support (Liz: 177-199). However, despite these examples of supportive workplaces, a fear of being judged as 'weak' remains the dominant experience. It appears that supportive workplaces reflect the attitudes of individual charge nurses rather than a move away from the general expectation of being a 'super-nurse'. This variation would seem to fit with the findings of Smith and Gray who note that it is the charge nurse who sets the rules, providing a role model and legitimation for students in the provision of emotionally explicit patient care (Smith and Gray, 2000). In this case, charge nurses like Liz seem to be setting the rules for the whole ward in terms of the acceptability of asking for and receiving help.

Unlike Eileen, who feels well supported, nurses who are not lucky enough to work in explicitly supportive teams have to judge whether it is safe for them to ask for help. What is safe in one working environment will not necessarily be safe in another. While some participants describe successfully asking for help, others have been less well received. Karen describes a conversation with her nurse manager after a colleague wrote a letter of complaint about the impact of low staffing levels on herself and her colleagues:

some time ago, when one of the members of staff left because she felt she wasn't giving a satisfactory level of care, she wrote a letter as did *another* E grade staff nurse, to our manager, saying that they were concerned about the actual *amount* of staff that we had on the ward at that time. There were so few experienced specialist nurses and they just couldn't *cope* with it. And he was very, very sympathetic and expressed his concern and says, 'What can I do?'. Our *senior* manager, a couple of weeks later on she spoke to me and said that she thought it was particularly *unhelpful* having staff writing letters such as that to a manager and if they couldn't cope with it then they were as well getting out of the profession (Karen: 440-458)

Lindsay describes a similar situation in which colleagues were 'literally screamed and bawled at' by their line manager for complaining that the staffing levels in their workplace were unsafe (Lindsay: 613-625). Christine's experience of seeking help was less harsh, but nevertheless caused her some distress; after mustering the courage to talk to her manager about her unhappiness and thoughts about leaving, the manager's response was to laugh and say 'you won't' (Christine: 885-887). For this manager, the idea of leaving does not seem to have been one that could be seriously entertained and this prevented her from offering the support that Christine was asking for.

Lindsay's account of a particularly traumatic time when she was a theatre nurse indicates the assessment that nurses have to make regarding the safety of admitting their need for support. Within a short space of time, she was present at the deaths of two children on the operating table. These were the first deaths she had witnessed since the birth of her own children, and as such they were particularly difficult. On one of these occasions she received help from a friend:

The only support I got from anybody was one of the staff nurses who was a personal friend. She gave me time out to handle the situation. She kicked everybody out of theatre and let me hold the baby and just grieve appropriately whereas management, just 'Get on with it'.

They gave you no counselling, no support whatsoever. None at all  
(Lindsay: 200-205)

On the other occasion the support she received had a more clandestine feel to it.

I had *one* opportunity to talk to one of the nurses that was involved with it as well as myself. I was actually scrubbed for it and *all* we had was a quick conversation in a cupboard. And that was it.  
(Lindsay: 219-222)

Lindsay seems to have been careful whom she spoke to about these incidents, indicating that the label of being weak was significant in the wider sense of the power games being played out in her workplace:

a lot of people I just didn't show it to because I didn't want them to know how I was feeling because I'd feel that I'd have my children thrown back at me because I was a Mum. and [the reason why] I was behaving in this manner was because I was a Mum and I didn't want them to know that. I didn't want to be made to feel *weak* by them because there was very much a power thing. (Lindsay: 277-284)

Lindsay's fear of being judged as weak may have been strengthened by her previous experiences of bullying (Lindsay: 150, 662), a phenomenon that is common in the NHS and in nursing in particular (Hadikin and O'Driscoll, 2000). The subject of bullying appears frequently in nursing journals (e.g. Hampshire, 2000a; Lee, 2000; O'Dowd, 2000b, Schubert, 2000; Daly, 2001a) and the extent of the problem is suggested by the 'deluge' of calls and letters, received by the *Nursing Times* (Nursing Times, 2000c; Cox and Wallace, 2000), in response to the publication of two articles addressing the subject of bullying at work and how to deal with it (Walker, 2000; Grove, 2000). Indeed, Freshwater claims that 'the nursing world is rife with aggressive and destructive behaviours propagated by nurses on nurses.' (Freshwater, 2000: 482). For some, the price of admitting weakness may be a high one.

While Lindsay sought help from people she trusted, other nurses decide against asking for help and battle on alone. Elizabeth persevered to the point of exhaustion. When I asked if she had spoken to her anyone about her difficulties, she responded:

not to my colleagues. It was almost seen as 'Oh you must be *weak* and not up to the job if that's how you feel'. They've been through it and you get on with it sort of thing was the attitude. It just wasn't even an issue. I just didn't feel I could speak to anybody about it on the ward. There just wasn't any support there for me so I suppose they all had their own pressures as well but there wasn't that mutual support. (Elizabeth: 348-369)

Lesley was so successful in masking her feelings that her colleagues were extremely surprised when she announced that she was leaving (Lesley: 497-500). Margaret also masked her difficulties in coping as a newly qualified staff nurse and kept her difficulties from her husband as well as her colleagues:

I was newly qualified and it was just so heavy in every way, physically, emotionally. And I didn't realise it bothered me until ... for weeks and weeks I was narky with my good man who I had *never* any reason to be narky with. He just [said] one day 'What is wrong?' and I burst into tears and it was all just about work and how I just wasn't coping. I *was* coping but I didn't like having to cope on my own. I didn't like not having the support. Eventually I spoke to the ward sister who is really very approachable and that helped (Margaret: 225-233)

Margaret's belief that she had to cope alone prevented her from receiving the support that her ward sister was quite willing to give her.

Those who advocate the provision of clinical supervision take a more supportive approach to the problems that nurses face in their work (e.g. Butterworth and Faugier, 1993). Clinical supervision involves the provision of each nurse with a regular opportunity to discuss her work with an independent supervisor whose role is:

to facilitate **growth** both educationally and personally in the supervisee, whilst providing essential **support** to their developing clinical autonomy. (Faugier, 1993: 24).

Although in 1995, the UKCC issued a statement that all nurses should have access to clinical supervision (UKCC, 1995), the provision of this form of support is still not mandatory in the NHS, and many nurses have been reluctant to participate, even when supervision has been provided (Cutcliffe and Proctor, 1998). Their suspicion of this form of support is echoed by Gilbert who suggests that the rhetoric masks a bureaucratic agenda in which supervision provides the opportunity for surveillance over the activities of health care professionals (Gilbert, 2001). Gilbert's sense of unease surrounding the agenda that are driving the introduction of clinical supervision seems to be shared by many nurses who see supervision as 'yet another management monitoring tool' (Cutcliffe and Proctor, 1998: 283). Their fears may well be grounded given the widespread confusion between clinical and managerial supervision that has been identified by Yegdich (1999). The uptake of clinical supervision by nurses is also hampered by 'a tradition and culture that discourage

the public expression of emotion' (Cutcliffe and Proctor, 1998: 283), and further confusion between the concepts of clinical supervision and personal therapy (ibid.; Yegdich, 1999). In the light of nurses' emphasis on the importance of emotional strength, and the nature of both nursing and the NHS, the limited impact of clinical supervision on nursing is unsurprising.

Support for nurses is also provided in the form of counselling services, the need for which was identified by Briggs as a top priority in 1972 (Mackay, 1989). However, as with clinical supervision, provision of this service is patchy and has been described as 'at worst tokenistic and at best too little too late' for many nurses (Mulholland, 2002a: 4). These comments were made in the context of a recent Court of Appeal ruling that:

an employer who offers a confidential service, with referral to appropriate counselling or treatment services is unlikely to be found in breach of duty. (cited by Reid, 2002: 3)

Mulholland argues that this ruling will create a situation in which counselling services are provided by Trusts as a protection against litigation rather than as a means of support for staff, and will prevent nurses from suing their employers for damage to their mental health. Once again, it seems that the support available to nurses is undermined by a climate of suspicion that adds to nurses' unwillingness to ask for or accept help.

In a recent conversation with a friend who works with terminally ill people I encountered one nurse's resistance to the provision of such support systems at work. I asked if she has any official support mechanisms. She replied that are none, and that she has no need of any as she is able to provide her own support, drawing on the strength that she developed during the terminal illness of her mother (personal communication, 2002). The idea of clinical supervision and counselling may seem like attractive solutions to the problems of low morale and burnout among nurses. However, without a corresponding challenge to the climate of suspicion in the NHS and the discourse of coping and individual strength in nursing it seems unlikely that many nurses will feel either willing or able to accept the support offered.

## Seeking Support Beyond the Workplace

While some nurses may believe themselves to be strong carers who have no need of support, others rely on external support systems that do not carry the risk of being labelled by colleagues as 'weak'. In the absence of a supportive working environment, several participants speak of the importance of friends and family in providing an alternative means of support. Like Margaret's husband, Jane's boyfriend bears the brunt of her feelings:

My boyfriend gets it for about an hour when I get home. I get allocated moaning time and then I have to stop. (Jane: 366-369)

However, relying on family and friends who have no experience of the kind of problems that nurses face has its pitfalls. For example, Karen's husband's sympathy quickly faded as he became frustrated with hearing the same moans again and again. His expectation that Karen should be able to address her own problems does not seem to match her own sense of powerlessness.

my husband started off being quite sympathetic towards that and then he's getting like 'Nah, I don't care. I just want you to come home and if you've really got a big problem then discuss it with me, fair enough but do something about it'. (Karen: 292-301)

In some instances participants need the support of people who understand their situation from the inside, but who are not a part of their working lives. For example, Sue talks about the support that she receives from a close friend who is also a nurse (Sue: 602-609). For Lindsay, the nature of her distress at having to care for severely burned children, and her husband's reluctance to listen, prevented her from sharing the full horror of her experience with him. Instead she turned to her mother, whom she saw as having greater insight into her situation:

My husband wasn't very good but my Mum was, my Mum was. She was quite supportive. She's had experience, having unfortunately come across a child in the same situation and how she's reacted. So actually I could bounce off all the thoughts that were going on in my head with her you know...

... my husband I don't think wanted to think too hard about it because it was too raw, too emotional for him. He just won't open up to that too much. He's sympathetic but you can't be graphic and there's not many people you can be graphic to. (Lindsay: 269-250)

Part of Lindsay's choice of support in this instance seems to reflect a belief that, having been through a similar situation, there was less of a risk that her mother

would be damaged by her confidences. However, Robbins, an expert in counselling survivors of extreme trauma, claims that counsellors often find themselves isolated from their families by the intensity of their experiences at work (Robbins, 2001). While nurses like Lindsay may hesitate to burden loved ones with the details of their working lives, family members may also protect themselves by refusing to listen. Such a reaction is suggested in the response of Florence Nightingale's family to her letters home from the Crimea, since her parents cut out the graphic accounts of her work before circulating the letters to the rest of the family (BBC, 2001b). Several participants show concern that their work causes problems for their family as well as themselves. Maria and Elizabeth both indicate that their relationships with their husbands have suffered as a result of problems at work (Maria: 161-163; Elizabeth: 123-133), and while focusing on the negative changes in herself, Lesley's account of her husband's response to her difficulties suggests that he suffered too:

I don't really think my husband could have taken much more of, of what was going on in the unit. He saw something. He thought they were killing me in a sense, kind of killing my spirit. And he just said 'You just can't go on like this, you know, you're never going to be able to, to nurse, they're not gonnae leave you alone. You're gonnae have to change.' (Lesley: 581-587)

These examples indicate that, while the existence of external support seems to enable some nurses to continue to 'battle on', others do not have, or cannot make use of, this important resource. In an occupation that promotes the idea of the super-nurse, and that inhibits nurses from seeking support from colleagues or seniors, individuals who lack external support mechanisms may find themselves carrying an intolerable burden alone. This burden may be intensified if their attempts to seek help at work are rejected. Some of these nurses may continue to accept the *status quo*, seeing no other acceptable option, but others like Frances, take the next step of speaking out and trying to change the situation that is causing their distress.

### **Challenging the Status Quo**

In chapter three I described the contrast between nurses' professional aspiration to use their judgement and speak out on behalf of patients, and a continuing tendency towards passivity and acceptance of the status quo. Oakley notes this tendency,



ascribing it to the close connections between the discourses of the good woman and the good nurse:

Real women are not supposed to be revolutionaries. If we complain about our situation, or the system, we are likely to be called ill, neurotic, menopausal, premenstrual, or in need of some curative relationship with a man (Oakley, 1984).

A nurse who speaks out risks more than being labelled as a bad nurse. As McDonald and Ahern (2000) demonstrate, a nurse who speaks out, or becomes a 'whistleblower', may face unofficial sanctions in the form of threats, rejection by her colleagues including the label of 'traitor', and pressure to resign or blocking of progression in her career by her seniors. She may also face official disciplinary action such as demotion, a reprimand or even referral to a psychiatrist (ibid.).

As with the question of seeking support, nurses who wish to challenge the status quo and change their situation often need to consider whether the risks involved are worthwhile. Although Lesley relished her role as an innovator, and Frances successfully approached her seniors in order that her colleague's problems could be addressed, other nurses speak of banging their heads against a brick wall (Valerie: 149; Gemma: 991; Eileen: 960; Jean: 866) or simply continue in their attempts to cope.

In some cases, participants indicate that their attempts to change their situation focus more on their own behaviour and attitudes than on those of their colleagues and managers, or on the structures in which they work. Frances survived through a particularly difficult period by carrying her letter of resignation in her uniform pocket, a measure that increased her sense of control even if it did nothing to change the reality of her working situation.

I had *two* of them. I had one that I would have been happy to have in my file, 'Dear sir / madam, ...' it's a very posh one you know, and the other one was 'Stick your job up yer jersey!' ...

... and it was a powerful letter because I had it there, I carried it, and I may sound pathetic but I was very junior and I carried some power in that bag, so through the day I'd look at that letter and [think] 'I might not, but I *might*.' (Frances: 804-813)

While Frances' letters changed her feelings rather than her behaviour, other participants' responses lead to changes in both areas. For several participants, the crucial catalyst was the birth of a child. Indeed, Jane claims that her colleagues see

having a baby as an acceptable route out of the wards or into less pressured part time work (Jane: 649-677). For Christine, having a child meant reassessing her priorities and deciding that, although she was still passionate about nursing, she could not continue to work at the same level:

I think it was very much a standing back and thinking 'God what were you doing?' I mean, you're burning out but also to the effect on other people, and at the end of the day the service was no worse off and I was no better. You know, whatever you do, people are going to expect you to do anyway. They weren't going to see any better of me for doing these things or not doing these things. (Christine: 345-350)

As I showed in chapter four, for Christine, maternity leave not only led to changes in her willingness to work long hours, it also focused her attention on how much her work meant to her as a source of identity. In this case, maternity leave appears to have simultaneously strengthened her commitment to her work, and altered her perception of what she needs to do to fulfil that commitment.

In contrast, Elizabeth found that becoming a mother changed her priorities entirely. She began her nursing career with a commitment that led her to give until she was exhausted, but as a mother she sees nursing in a very different light:

It's *such* a hard thing because you don't go into nursing for trifling reasons, it's part of *you*, it's part of the person you *are* and giving that up is quite a hard thing. But I have other cares and dependants now and the priorities have changed and I have an expression for that care in my family and that is my *absolute* priority. To go back to nursing and to give out as I was doing before, I couldn't do that. No. that would take too much from my family and I'm not prepared to *do* that. My children get my energy and that's how I want it to be. My job is always going to be secondary to that and I don't want *any* job that's going to take too much away from my children. (Elizabeth: 407-417)

Elizabeth's shift of focus, from nursing to her children, suggests that the experiences of nurses during the early months of motherhood deserve closer attention. It seems likely that this is a key turning point for many nurses who use their time away from work to reflect on where their lives and careers are going. A better understanding of their thoughts and experiences, may help employers to develop policies that encourage and enable nurses to return to work after starting a family.

For Claire, the crucial point was not having a child, since this occurred at the end of her training and so had to be incorporated into her working life from a very early stage. However, she too had to make a radical reassessment of her priorities when her source of childcare disappeared and she was no longer able to continue working in the same way. As a result she was penalised by her colleagues and seniors. Christine now works long hours at home to compensate for her reduced flexibility at work, and Elizabeth has left nursing completely in order to fulfil her family commitments. Changing one's priorities is no more an easy option than seeking to change the situation in one's workplace. Although some nurses are successful and find satisfaction in their work again, others are not and may lose hope in the possibility of their situation improving. Of these, some will battle on while others will take the more active step of seeking a new post in the hope that it will be better.

### **Moving On**

For several participants, moving to a new post provided an acceptable answer to an intolerable situation. Since frequent moves are an accepted part of a nurse's career, she can change post without having to voice her dissatisfaction and risk the consequences. When Christine could no longer tolerate the stress of her work, she effectively demoted herself in swapping an F grade post for an E (50-67). Maria also sought answers in a new post, a strategy that was recognised by one nurse who was interviewing her:

it took me a good year to finally get out but then I was being silly. I was applying for other jobs and I thought 'I'm just applying for these and I don't really want them. I just want to get out'. And I went for an interview and they said exactly that. They said 'Your whole vibe sounds as if you just want to get out but you're not interested in the area' (Maria: 511-515)

As a student, Mark found it possible to continue his training by holding on to the thought that he would move on at the end of each placement (Mark: 171-172), and as a staff nurse, changing post made it possible for him to remain in nursing when he had considered leaving altogether:

the whole thing about coming here was 'Let's get some enjoyment out of the job again and let's see if it is different somewhere else.' (Mark: 686-694)

For Gemma, changing posts is a means by which she protects her own mental health:

maybe that's why I never got to the burned out stage where I thought 'No I've had enough of this. I can't cope with it any longer and I have to move on'. I've always, always said to myself that I would move on before I ever got to that stage. (Gemma: 1186-1189)

For some participants, changing posts is not simply a matter of submitting an application but requires investment in further training. For example, in chapter four I described how Kate was prepared to invest an enormous amount of energy in completing her degree whilst caring for a new baby. She did this in order to gain the qualifications that she needed to apply for a G grade specialist post. Her investment appears to have been fruitful since she now has a flexibility and income that allow her greater freedom to make her own decisions regarding her working hours and childcare provision. (Kate: 512-519). Although both Gemma and Christine work long hours at home, they too have found that a specialist post allows greater flexibility than that of a ward based staff nurse

Although nurses change posts for a wide variety of reasons, these examples suggest that the current high levels of turnover reflect, in part, nurses' quest for a less stressful and more satisfying post, and one that will combine more easily with their personal commitments. This observation is supported by the 2002 RCN membership survey that claims that 14% of respondents changed post in the previous twelve months in response to harassment or bullying (RCN, 2003e: 4). The fact that so many nurses move so often suggests that in many cases these changes do not deliver the expected improvements. Although changing posts is an effective strategy for some nurses, the systemic nature of the problems described in chapters three to five means that many people find themselves in a similar situation in their new post. When this happens, or when nurses recognise that the problems they face extend beyond their current place of work, some take the step of retraining in a new speciality in the hope that it will be better.

### **Re-Training in a New Speciality**

Of those participants who moved to a new speciality in order to find a more satisfactory position, most chose to leave the hospital setting for a branch of community nursing. As a hospital staff nurse I rapidly came to the conclusion that

my career choice was having an extremely negative effect on my mental and physical health. I was also frustrated by the extent to which I was unable to put into practice the knowledge and skills that I had developed as an undergraduate student nurse. I made a deliberate decision to change to community nursing, which I perceived as being less frenetic and offering a greater degree of autonomy and challenge.

Participants with community backgrounds supported my initial hunch that my reasons for moving to the community may be shared by other nurses. For Jean, Judy, Eileen and Anne, a large part of the attraction in district nursing lay in their belief that it would offer greater opportunities for spending time with and getting to know their patients (Jean 30-41; Judy: 188-194; Eileen: 914-927; Anne: 83-93). For several participants, the desire to spend more time with patients is associated with a need for greater autonomy in their work. Jean, Anne and Judy all speak of their frustration as hospital nurses whose practise was limited by the rigidity of protocols and policies, and a sense of being constantly under surveillance (Jean: 30-41, 1206-1211; Anne: 763-764; Judy: 197-207). Judy actually left nursing when she qualified in response to her frustration at the rigidity of hospital life but later returned and trained as a district nurse (Judy: 117-126). In district nursing these participants sought greater freedom to take responsibility for making the decisions regarding their own practice. Several participants also sought escape from a feeling of subservience within an intensely hierarchical hospital system. For example, Judy speaks of how she felt as if she should curtsy every time a senior nurse came onto her ward (Judy: 132), and for Barbara, leaving hospital nursing became something of an imperative before she found herself in trouble:

instead of just pulling at my forelock and accepting it, I would argue, and I realised that my days were greatly numbered if I was going to do that (laughs). So, whereas you are very autonomous in district nursing most of the time you see, you're your own master. (Barbara: 911-914)

While Eileen chose community nursing as an option that posed less conflict with her family commitments (Eileen: 892-908), for Claire, health visiting provides a stimulating career that builds on a long-standing interest in child protection (Claire: 131-148). However, the G grade salary, more predictable hours and greater autonomy facilitate the combination of working and family responsibilities. For Lindsay, school nursing provides similar benefits and has enabled her to remain

within nursing after a period during which she came extremely close to leaving altogether (Lindsay: 184-194).

Unlike Maria, who was prepared to apply for any job that would offer a means of escape, these community nurses, and those who applied for specialist nurse posts<sup>66</sup>, made their choice carefully. Their responses to dissatisfaction represent much more than an escape from an intolerable situation; they have actively sought out a working role that promises a greater freedom to determine their own practise and to combine multiple commitments. Both the specialist nurses and the community nurses have moved to those areas of nursing where there is the greatest opportunity to exploit the lack of clear boundaries to their own advantage. The community nurses have moved away from both the official surveillance of the hospital system, and the unofficial control imposed by being a member of a ward team. Although they continue to work in teams, most of their work is carried out alone and there is a more collegial, supportive environment. This differs from the emphasis that hospital teams place on uniformity of action and collective responsibility. The specialist nurses have stepped outside of the ward team whilst remaining in a hospital setting. Furthermore, in changing the structure of their role from an attachment to one consultant, to an attachment to a department (Emma: personal communication, 2001; Kate: 17-23), they have gained greater freedom from medical as well as nursing control. This relative freedom experienced by specialist nurses and community nurses enables them to shape their practice in ways that come closer to their own understanding of nursing, and to push the boundaries in the directions that interest them most.

For most of the participants cited above, their choice of speciality has been relatively successful and they have no plans to leave nursing. The accounts of the community nurses in particular generally reflect a far less pressured and more patient centred experience of work than that of hospital based participants. This group also talk of, and express, much less frustration. However, not every nurse who changes speciality finds the answer to her problems. For example, Jean's frustration and fury at increased workloads, a lack of resources and staff shortages

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<sup>66</sup> Although the participants who are specialist nurses have not changed speciality they have also moved to a new post that involves a completely different way of working and demands a high level of training. For these reasons their move is closer to a change in speciality than to a move between posts.

that impact on the quality and delivery of patient care in the community are evident even two years after she left nursing:

I routinely would *come back* on a Thursday and, and spend at least the first hour of the day phoning people to apologise. 'Did you not get what was supposed to happen on my days off?' 'Well, yes, I know I've assessed you as needing this *but* social work haven't got that. *We* haven't got that'. 'Yes you should be having somebody to come and give you a bath (laughs/sighs) but I'm sorry, I've not got any auxiliary space 'til about the year 2010.' I mean it was just crazy. (Jean: 150-157)

Jean's feelings echo those of district nurses participating in Traynor et al's study of morale among community nursing who also complain that administrative concerns and staffing issues prevent them from focusing on patients' needs (Traynor et al, 1994).

Those who find that they are still frustrated and unhappy, after expending a great deal of effort in order to change speciality, can experience a profound sense of hopelessness. It is this feeling more than anything else that characterises those participants who have chosen to leave nursing altogether. However, while some nurses do see leaving as a possible option, for others it is inconceivable, a position that may leave them feeling trapped.

### **BECOMING TRAPPED IN AN IMPOSSIBLE SITUATION**

In previous chapters I showed how, despite the personal costs involved in nursing, participants share a deep sense of commitment to their work, which has incorporated itself into their sense of identity and self worth. This is a situation that can create enormous difficulties for nurses who lose hope in the possibility of finding a post in which they can feel happy and fulfilled. For some, leaving is an extremely difficult choice to make when all sense of hope fails, but for others it is simply not a possibility. Although they may express or feel the desire to give up the struggle and leave nursing, their commitment to patients as vulnerable people in need of support and care, and their deep involvement in nursing inhibit them from doing so. As I showed in chapter three, for nurses like Kate, a lack of self-confidence creates the belief that there is nothing else that they can do. Financial and personal circumstances may add to this perception that there is no choice but to continue nursing. For example, despite her initial satisfaction with her move into

the community, Barbara eventually found herself in a situation where bullying was widespread and many of her colleagues had left. She felt burnt out, her health deteriorated (775). She spent every Sunday dreading her return to work and every weekday 'treading on eggshells' (708-709)

Barbara [I felt] very sad actually because I'd wanted to nurse since I was twelve. I found it very, very sad. It was too frightening, the prospect of nursing, because it had been so bad. And yet it saddened me so much that I was reduced to this and [I] just couldn't consider or even *conceive* the idea that I would nurse but I thought it was [a] very sad and tragic situation.

Alison Did you think at that time of other things that you could do?

Barbara (...) No, I think that was the problem as well. That's why I could never get away because I couldn't think of anything else to do. I certainly couldn't go back into hospitals, it's been too long and I didn't particularly want to, and like I say, district nursing in another area didn't seem any more attractive at that time because I could be going from one miserable situation into another one. (Barbara: 779-791)

Barbara finally reached a point where she couldn't continue and took the drastic step of selling everything she had, including her home, and going travelling in order to give herself a break. This was not a decision to leave nursing but a break from the pressure she had been under (Barbara: 690-692). When she returned, a friend persuaded her to apply for a new district nursing post, which renewed her enthusiasm and solved her dilemma (Barbara: 832-856). Barbara was able to take this drastic measure of selling up because she had no dependants. However, many other nurses find themselves in an impossible situation where continuing in nursing and leaving are equally inconceivable options. It may be that this phenomenon contributes to the high levels of sickness and burn out among nurses who persevere from day to day, unable to find a solution to their dilemma.

## **WHEN LEAVING IS A POSSIBLE OPTION**

Although several participants claim that they cannot imagine leaving nursing, or cannot see any alternative options, some are making definite plans to leave and others have already done so. These participants share several key characteristics: they see no future for themselves in nursing; they recognise the skills they possess



and consequently can identify possible alternatives to nursing; they have a strong sense of self preservation and sufficient self confidence to overcome the pressures exerted upon them to stay; they are also idealistic people who are strongly motivated to leave by a deep frustration born of a strong commitment. The decision that these nurses have taken represents the culmination of a period in which they have sought alternative answers and, in most cases, they have agonised over their decision and found leaving a very hard choice indeed.

### **Recognising Alternative Career Options**

In contrast to the belief expressed by Kate, that she cannot leave because nursing is all she can do, other nurses recognise the extent to which skills developed within nursing open the door to a variety of alternative occupations:

I think being a nurse you could just about do any job 'cause you have to deal with the public, you have to deal with managers and conflict in situations, you have to deal with time management, you have to deal with finances, you have to deal with such a wide range. I think it makes you a very eclectic person, you can turn your hand to whatever, and you are usually juggling more than one task in your brain at once. You're not only doin' a practical task, you're doin' a knowledge task, you're doin' all of that at once. I think you would need to gain knowledge to do any other job but I think you've got the skills to take them into [almost anything] (Gemma: 434-448)

Gemma's perspective on the transferability of her skills is shared by Eileen (748-722), Jane (778-792), Margaret (409-418) and Lesley (818-831). Both Lesley and Valerie have already made use of their skills in other fields, and Valerie demonstrates her willingness to move between fields claiming 'I'm just gonna do whatever needs to be done that comes my way.' (Valerie: 841-842). Jane (139-140) and Margaret (476-477) are planning to use their nursing skills in medicine and teaching respectively and, although Robert has no plans to leave, he is willing to accept any tempting opportunities outside of nursing that may appear (677-682). For these people, nursing has provided the opportunity to develop valuable skills that open a wide range of alternative career options to them.

## Overcoming Opposition and Feelings of Guilt

Although an awareness that she has skills and knowledge that will enable her to work in a variety of occupations is important, it does not necessarily enable a nurse to leave. She must also have the self-confidence and motivation to act upon her desire to leave, despite the pressure that others may exert upon her to stay. For example, both Elizabeth and Valerie speak of how their husbands liked the fact that they were nurses and tried to discourage them from leaving (Elizabeth: 634-643; Valerie: 823-827). Some participants encountered opposition from strangers who felt that nurses should not leave. During the University Milk Round,<sup>67</sup> Heather explored the other options available to her before deciding to use her nursing qualification. She describes how company representatives turned her away, reminding her that she was a nurse in very patronising terms (Heather: 29-33). During a planning meeting for this study, nurses on one ward discussed the experiences of a colleague who had applied to a well-known chain store for a job. She was told that they would not consider recruiting any nurses due to the problems that the NHS is currently experiencing with shortages (personal communication, 2001). This is a purely anecdotal account and does not necessarily indicate that this is either company policy or a widespread attitude among potential employers. However, it does demonstrate that such stories are circulating among nurses, and this in itself is likely to shape their willingness to seek alternative forms of employment.

One of the most powerful ways in which other people can influence nurses who are thinking of leaving is the prompting of feelings of guilt. When Clare Donaldson, a district nurse, decided that she could no longer continue nursing, and told her colleagues that she was thinking of becoming a complementary therapist instead, they described her as a 'fallen angel' (Donaldson, 2000). This is a powerful metaphor, drawing upon both the popular imagery of nurses as angels, and the Christian story of the origins of evil. The original fallen angel was Lucifer, or Satan, who rebelled against God and was expelled from heaven. In applying this label, Clare Donaldson's colleagues appear to be making a very strong statement about the unacceptability of leaving nursing. A nurse who rejects her commitment by

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<sup>67</sup> This is the title given to the careers fairs that are organised for students who are about to graduate from university.

leaving is no longer an angel but a sinner. A similar morally judgmental attitude is apparent in the case of the nurse cited in chapter three, who is currently re-training as a doctor. She describes how she has to keep her past a secret as the nurses who already know her history treat her move as a 'betrayal' (White, 2002).

The strong emphasis that nursing discourse places on commitment as a moral imperative means that nurses are particularly vulnerable to feelings of guilt. Such feelings are likely to be intensified by the value judgements that are implicit in the language of nursing shortages and wastage in the media and in research circles. For example, references to nurses' 'desertion' (e.g. Buchan, 1996: 2; *Nursing Times*, 2002) seem to suggest some form of wrongdoing or lack of loyalty; and the word 'quit', that appears in many headlines, is one that is often used to describe people who give up easily (e.g. Crail, 1997: 11; *Health Service Journal*, 1998: 8; *Nursing Times*, 2000c: 14; O'Dowd and Payne, 2000: 5; *Nursing Times*, 2001; *Nursing Times*, 2002: 9). Soothill et al also point to the morally judgmental language of 'wastage':

the term 'wastage' is one which nurses readily internalize. It has intimations of sin, guilt and letting down the service. Nursing still retains enough of the notions of a vocation to suggest that nurses who leave are rejecting their calling. So all this adds to the pressure nurses already suffer in trying to conform to the popular image of the caring, all-giving nurse without being regarded as a waste if she takes a break from nursing or turns her ambitions to the apparently greener grasses of other occupations (Soothill et al, 1996: 269)

For Christine, the moral imperative to care and the sense of self-worth that accompanies her work are important reasons why she has not acted upon her desire to leave:

it's the same old thing that always pulls me back to the service is that the patients need nurses like me. I think they need clinical people. And also my colleagues because I know that they respect me as a person, my knowledge base, all these kinds of things. And I just thought 'There's so many people moving out of the service or side stepping at the senior levels, that I thought that there's no expertise at the shop floor. So it was all those kind of things that made me think 'You are worthwhile. All these other people think that you're worth while it's just that management maybe didn't see the priority of that. (Christine: 366-374)

Christine feels needed and valued by her patients and colleagues and ultimately this is enough to keep her within nursing. Her decision is grounded in a belief that many nurses are leaving and her observation that there are not enough experienced

nurses in the service. In her eyes, it seems that leaving would involve abandoning not only her patients but also her colleagues who need her.

Other participants succeeded in overcoming their feelings of guilt and the pressure exerted by colleagues. Although Lesley did not seem to have thought about the implications for her colleagues and patients before she decided to leave, their reactions to the news left her with an immense feeling of guilt and doubt about whether she had made the right decision:

the majority of people they just found it incredible and were begging me not to do it. And the medical staff held an emergency meeting and my consultant just said 'You can't do that. Can you not stay and work part time whatever?'. The patients were just so shocked. I hadn't realised how dependant perhaps they could be to know that that person was *always there*, they are *always* on the end of a bleep. You *don't* have to go through lots of doctors who don't know about your condition and your family circumstances. I think the most significant thing was a patient I'd been treating and he said to me, 'This is just terrible. I feel like a light has gone out in my life to know that you just sort everything out from my bowels to my ... it's just everything. You *know what to do*'. And that made me really feel quite guilty about that level of expertise. How can you walk away after all those years with *that level* of knowledge? I felt *really, really* guilty, *really* guilty about it. (Lesley: 485-520)

Ultimately Lesley stood by her decision and left to set up her own business. She was able to overcome her feelings of guilt due to the vital support of her family (576-577) and friends:

See people always used to say to me 'You're so talented. You've got so many skills, you could go far.' And *doctors* were always encouraging me. They used to always just say 'What are you doing? You're gonnae run out and you're gonnae become bored of this.'...

...and most people's reactions [when I left] were 'Good on you, you've been *used* and you're worth so much more', and that was an encouragement although despite the nursing staff and things and tears and all of that, there was a lot of people who had maybe worked with me for six months and then moved on, a lot of the registrars, everybody was just *so* positive and saying 'Get out there and live your life.' (Lesley: 728-732, 738-745)

Despite identifying strongly with the role of nurse, Lesley appears to have retained a sense of herself as a person with needs of her own. This was supported by her husband's observation that nursing was killing her and her friend's observation that she was being used.

For some nurses, external validation of the reasonable nature of their desire to leave helps to overcome their feelings of guilt. In other cases, where nurses choose not to return after having a child, any guilt may be overcome by the rationalisation that the care the nurse provides for others is simply being transferred to another deserving object. This can be seen in Elizabeth's justification for not practising, cited earlier in this chapter. For women like Elizabeth and myself, leaving to care for a child carries less risk of condemnation for a lack of commitment than attributing the decision to dissatisfaction since children provide another legitimate outlet for a woman's vocation to care. Furthermore, this option reduces the likelihood that the person concerned will be asked to justify herself to others and in so doing open herself up to further criticism and guilt.

### **Fulfilling a Commitment to Oneself**

Despite the dominance of the discourse of the super-nurse who sacrifices her own needs in the service of others, it appears that some nurses retain a commitment to their own well-being and happiness. A strong sense of identity and self-worth beyond being a nurse is one of the main characteristics shared by participants who have left nursing. For example, Valerie speaks of her belief in the need to love and value yourself (Valerie: 974), a belief that enabled her to leave nursing when her seniors 'quit listening' and she found that she could no longer work effectively as a manager (Valerie: 288-290, 322-323). Several other participants ask why they should be expected to give so much to their work for so little return, financial or otherwise. For example, Elizabeth comments that 'ultimately there are limits to what I would accept' (Elizabeth: 338-343), and Margaret, who is planning to leave nursing and move abroad, asks: 'Well if I don't have to work that hard, why should I?' (Margaret: 748). She seems to have come to the conclusion that her view of nursing as holistic care is an impossible dream that there is little point in pursuing (762-776). She gains neither the satisfaction from a job well done (430), nor the respect she believes she deserves (520-527), and so has decided that there is little point in continuing within nursing. Her decision to start a new life, in which she can take life easy and enjoy the sunshine, has been influenced by her close contact with death.

you used to see these 'Pepsi-Max' adverts 'Living Life to the Full' or 'Living Life on the Edge' and I thought 'I don't *do* that I don't do *anything* like that. I want to *do* more stuff. I just don't want to turn around in twenty years and feel that I haven't done all I could. As I say, it's just been a few young people I've seen dying the last six months or year that have made me think, you don't know what's around the corner. I don't want to (...) [very quietly] lose ... (Margaret: 160-167)

For Margaret, having the chance to enjoy life and grasp the opportunities available to her has become more important than a commitment to her work as a nurse, which has become an impossible dream.

### **Leaving as a Consequence of Commitment**

Although a sense of self preservation is an important part of nurses' decision to leave, many are also motivated by the very idealism and commitment that some people claim are lacking in leavers. As I showed in previous chapters, an enthusiasm for and commitment to their work is a characteristic shared by all of the participants in this study, including those who have left. As 'ex-nurses', Elizabeth, Lesley, Mark, Jean and Valerie all speak with passion about their work as nurses. Although Margaret and Jane are planning to leave, they too demonstrate a strong commitment to the ideals of patient centred care and high standards. For Lindsay and Barbara, who both came extremely close to leaving, the prospect was a difficult one and they show relief that they found a post that enabled them to continue nursing.

For some nurses it seems that, far from indicating a lack of commitment, leaving is a choice that is rooted in a strong commitment and idealism. A similar conclusion is reached by Spouse (2000) who describes how an inability to fulfil an ideal of nursing lies behind some students' decision to leave, and by the authors of a DoH report which claims that many people who leave the NHS do so in order to offer the standard of care they aspire to (DoH, 2003b). Jane illustrates this phenomenon, describing how a senior colleague, who was a role model for her, decided that she could no longer continue nursing:

I just think she was a really, really good nurse and she was providing individual care for patients and *thinking* about what she was doing and thinking about the ward philosophy and how patients should be treated and then following that through rather than just trying to get

all the work done as quickly as possible. But she was quite frustrated with her job as well because she felt she didn't have enough time to do that. She ended up leaving because she just said she went home every night feeling like she had given crap care to her patients because she hadn't had enough time to do it (Jane: 212-223)

Karen's story of the nurse who wrote a letter of complaint to her manager, demonstrates the same sense of frustrated ideals that appear again in Donaldson's account of why she chose to leave nursing:

Actually I am only another nurse who has decided to leave the profession. Not because of the pay (G Grade). Not because of my working environment (a GP surgery in a pleasant city). Not because I have a child to look after (I was fortunate in being able to negotiate a job-share). I left because holistic care has been eroded from my job description and replaced by something resembling crisis management ... As far as I am concerned, I did not leave nursing. I left a job I no longer recognised and would never have chosen. I went into nursing to care. I left because I cared too much. Rather than be part of a fragmented network of crisis management, where standards of care had slipped beyond recognition, I chose to leave. (Donaldson, 2000)

For Margaret, a desire to leave nursing developed from a growing realisation that her ideal of holistic, patient centred nursing was far from the reality of hard physical labour and task oriented care. Elizabeth speaks of her unwillingness to return to nursing until conditions allow her to meet her own standards (Elizabeth: 262-271). Jean left because she could no longer see any way of fulfilling her commitment to patient centred, holistic care, and Lesley describes her decision to leave as a matter of principle:

I thought about it and I thought 'Well I *can't*, I can't do that. I can't come to this length in my nursing career and say I'm not a nurse of principle because I *am*.' And I just thought 'I'm not gonnae stand back and say that's acceptable.' (Lesley: 584-588)

For each of these people, the decision to leave was a painful one arrived at after a long period of trying to make it work and, as I will demonstrate later, these nurses' difficulties in taking the decision to leave did not always end when they left their place of work for the last time.

Although Spouse comments on the 'deeply embedded commitment' to nursing that nurses exhibit from their earliest days as students (Spouse, 2000: 737), as the interviews progressed, I began to wonder whether participants' commitment is specifically to nursing or whether nursing is simply the expression of a broader

commitment to caring for others. In the cases of some participants, this commitment to caring seems to conflict with their experience of NHS nursing as a dehumanising conveyor belt. For several of the ex-nurses in this study the focus of their commitment is the welfare of other people and nursing is simply one means by which they can fulfil this commitment.

In their accounts of how they came to choose nursing, many participants indicate that as school leavers or university graduates they set out with a broad desire to work with and help people. For example, Jean wanted a job that was practical and allowed her to deal directly with people (Jean: 415-431), and Eileen also wanted to be 'completely involved with people' (Eileen: 38-74). Kate, who comments that helping others makes her feel good about herself, wanted a job which would allow her to do this (Kate: 263-274, 208-210), and Mary simply wanted to be there to care for people in distress (Mary: 127). Heather, who describes herself as a student as 'an idealistic young thing', wanted a job through which she could 'put something back' (Heather: 23), and Christine, who came from a strongly socialist background, wanted to make a difference in people's lives (Christine: 80). This desire to help others shaped the kinds of work that participants were prepared to consider and, as a 'caring' job, nursing was simply one of a number of possible options that fulfilled their criteria. While Barbara (273) and Lindsay (31) were clear that they wanted to be nurses from childhood, most of the other participants considered a broad range of people centred jobs before deciding on nursing. For example, Ruth (29), Eileen (38) and Frances (102-109) all considered teaching; Jane (41-42), Gemma (98) and Frances (115-119) thought about becoming doctors; Christine considered both community education and social work (Christine: 39), the field which Mark chose when he left nursing; and Frances also considered midwifery (Frances: 101). The broad interest in people, which seems to underpin these jobs, is also seen in the accounts of Robert (80), Jean (6) and Sue (21-22) who completed respective degrees in psychology, social policy and sociology before training as nurses.

This initial orientation towards working with and caring for other people, rather than towards nursing, would seem to support Mackay's suggestion that the idea of a specific nursing vocation is one into which people are socialised early in their careers, rather than being the reason for choosing nursing (Mackay, 1989). Having begun their nursing careers with a broad commitment to caring, or even no



particular commitment at all, the breadth and focus of participants' commitments altered during the course of their careers. Several participants chose nursing from a range of vocational options but later came to feel such a strong affinity with nursing that they could not contemplate any other field (Elizabeth: 528; Eileen: 419). Karen, who had little idea of what nurses do, and who chose nursing for practical rather than idealistic reasons, had a similar experience:

I would have to confess that I had absolutely no aspirations to nursing at all. My sister was a nurse. She was doing her training and I thought it sounded like a whole lot of laughs and I was in sixth year at the time I was doing some more Highers. I wasn't enjoying it and I spoke to Mum and Dad about it and they said 'You're not leaving school' and I said 'What if I did nursing?' and they said 'Well, we'll consider that then' and that was the reason I became a nurse ...

... I think they probably thought that [in] nursing you were a bit better looked after, protected than you would be if you were just going off to be a student at university or whatever (Karen: 45-51, 72-75)

Despite this unpromising start to her career, Karen came to develop a passion for, and commitment to, nursing, which clearly shows in her interview, despite her frustration at the problems posed by inadequate resources, and staffing levels. Although she speaks of her dream of opening a coffee shop (Karen: 754-765), and can't imagine continuing in such a physical job until she retires (704-707), she says 'I can't quite imagine, you know, not nursing' (757).

In contrast, to Karen's specific commitment to nursing, other participants retain their broader caring focus and have found that they can easily contemplate moving to other fields of work. Both Jean and Valerie loved their work as nurses but found that they could leave nursing and transfer to other fields of work that also fulfil their basic desire to care for other people. Jean is now happy as a sheltered housing warden, a job that provides contact with people and the freedom to make her own decisions (310-317). Valerie still sees herself as continuing her commitment to care in her new role, teaching and practising complementary therapies, a route that she claims is also being taken by many of her students who are nurses (Valerie: 325-339).

## Leaving Nursing: An Easy Option?

Even when a nurse has the self-confidence and motivation to leave nursing behind and start a new career, this is by no means an easy option taken by people who lack the strength to remain. As Crouch claims, the question of whether to leave nursing or not is one with which many nurses 'wrestle' (Crouch, 2002). Deciding to leave is an experience that generates intense feelings of fear, sadness, regret and doubt. Mark describes leaving as a decision that took a lot of courage (81-83), while Mary abandoned any thoughts of leaving as being too frightening (Mary: 554-558). Although Lindsay eventually found a school nursing post that enabled her to stay, she went through a period of planning to leave in which she went as far as applying for training. She also describes this as a time of fear since she was planning to leave an environment that was familiar, if unhappy, and move on into the unknown (Lindsay: 649-667).

For those who are planning to leave, as well as for those who have already left, there can be a profound feeling of sadness and loss as Barbara showed earlier in this chapter. Margaret also speaks of her sadness at leaving (420, 423, 427, 479, 486, 521, 626, 640), an emotion that is evident throughout the interview in her low tones, frequent sighs and slow speech. Indeed, it is possible that despite her current certainty, Margaret may find leaving too difficult to go through with. Although her plans to move abroad are clear she also intends to move to a new post in the interim. The way in which she speaks of this move suggests that she may see it as nursing's 'last chance' to keep her although the possibility seems a remote one.

One of the most powerful accounts of the impact that leaving can have upon a nurse is provided by Lesley. Immediately after leaving she took a holiday in the USA that helped her to recover after the intense stress she had been through in the previous two years. On the flight home, as she returned to start a new life, the impact of what she was doing began to sink in:

when I came back I was sitting on the flight and I was howling, saying to my husband 'I don't know if I can cope. What am I going to *be*?' Because I'd given up my job, they had this big *lunch* and everything, and everybody came to it. I mean it felt *surreal*. This was like chopping off an *arm* for me. And then I was away to America the following day. Sitting on the aircraft coming back, I felt (...) so sort of scared for the future. I'd been brave. I knew I had to do it but I remember thinking 'Am I going to survive beyond what is my

frame of reference?’ and in some sense I was feeling, ‘Have I let my patients down?’ It took a long time. Even now thinking about it, you know, I, I find it really hard thinking ‘No, I did walk away.’ (Lesley: 703-714)

### **Leaving Nursing: A Final Decision?**

The division of nurses into ‘stayers’ and ‘leavers’ carries with it an air of finality that is not reflected in the experiences of participants in this study. Some, like Barbara and Judy have left and returned, while the finality of other participants’ decision is, at times, tempered by a desire to return or even the actual continuation of bank shifts. As I spoke to Jean of the experiences that lead her to leave nursing permanently, a copy of a nursing journal dropped through her letterbox. Although this was an unsolicited free copy Jean’s response highlights the pull back to nursing that people who have left can experience:

it’s difficult to get away from nursing, it *really, really* is. It took me a while to stop my subscription to *Nursing Times*. I’ve renewed my registration (laughter), just keeping my options open. (Jean: 316-325)

Although Jean claims that her decision to leave is final (1247-1249), she contemplates the possibility of returning as a HCA (Jean: 210-212). In this she would be following the example of some of her nursing acquaintances. These people are registered nurses but have chosen to take posts as HCAs where they can focus on patient care as an alternative to leaving nursing altogether (Jean: 373-377). I was unable to interview these people to confirm her story but an article in the *Nursing Times* (Buswell, 2000), describing similar behaviour among registered nurses suggests that this is a relatively widespread phenomenon that is worth researching further. In a paper written for the *Nursing Times*, Annie Woodcock describes how she made a similar choice in order to return to nursing from management (Woodcock, 2002). As a former ‘leaver’ who emigrated to the USA<sup>68</sup> to nurse, she chose to return to the UK and worked her way up from a junior practice nurse to a management post. However, she describes missing the camaraderie and patient contact and later chose to take a post as a bank nurse in Accident and Emergency at half her management salary (ibid.).

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<sup>68</sup> Annie’s experiences were the subject of a television documentary in the late 1980s entitled *Annie Doesn’t Work Here Anymore* (Crouch, 2002).

While Jean considers returning as a HCA, Mark continues to work bank shifts in his old department to fund his training as a social worker (Mark: 1046-1060). Lesley also returns for the occasional bank shift in response to the pressure exerted by colleagues, and speaks of her continuing attachment to nursing:

despite me sitting here and saying that I've set up a business, I've taken a *radical* to change my life, to build on what became a fairly negative and *quite crushing* experience. I still say that I'd hate to think that I didn't nurse somebody again. I can't imagine not having some kind of nursing interest, whether that be if I become very successful I'd be quite happy to fund some research or to maintain my relationships with my colleagues, and these things are very important to me. ... [it's] the vocational thing, I *can't* just say 'I'll never nurse again.' I might just do the odd bank shift (laughs) (Lesley: 832-851)

It seems that leaving may not be an event marking the end of a nursing career. Instead, it appears to be a process during which nurses make the transition to a new job and identity. Working bank shifts seems to serve as a means by which nurses can retain their registration while they wean themselves away from nursing gradually both emotionally and financially. The same conclusion is reached by the authors of the 2003 RCN membership survey report '*Stepping Stones*' who describe bank work as both a stepping stone back into nursing for returners and out of nursing for leavers (Ball and Pike, 2004). The weaning process can be seen in Liz and Emma's experience of transferring to management. Liz, who has been in her present role as manager for eighteen months, still misses her work on the wards and wonders whether she has made the right choice (Liz: 385-397). Emma has been away from clinical practise for longer and is content now but she describes how, during the first eighteen months away from the wards, she experienced feelings of uncertainty and loss similar to those expressed by Liz (Emma: 589-604). These accounts suggest that Liz may still be going through a grieving process as she adjusts to the loss of her role as a clinical nurse. It may be that she will eventually find the satisfaction in management that Emma describes.

In her reflections on the difficulty of leaving nursing, Jean refers to her registration as a means by which she can keep her options open. Gemma shares this perspective and, while talking about the possibility of leaving, points out that as long as she maintains her registration she can always return. Several other participants echo this perspective on nursing as a 'job for life' (Margaret: 73-76;

Kate: 81-83; Jane: 496-497; Emma: 32-43; Frances: 784-791) These examples suggest that, although some nurses may take a 'definite decision' to leave, the real marker of leaving is not ceasing to practise, but allowing one's registration to lapse.

## CONCLUSIONS

In this chapter I have shown how nurses weigh up the powerful rewards that nursing can offer against the negative aspects that often prompt a desire to leave the profession. This ongoing evaluation provides insights into the efforts that nurses make to find ways in which they can continue nursing. In the second part of the chapter I show that leaving is not an easy option for those lacking commitment, nor is it a discrete event resulting from a sudden decision. Rather, it is part of a process through which nurses struggle to stay and may, for some, be followed by a subsequent decision to return to practise.

One of the main policies designed to address the current shortage of nurses is a drive to re-recruit nurses who are no longer practising. If such a policy is to be effective, nurses must be open to the possibility of returning. The conclusion reached by a DoH report is that nurses who have chosen to leave are unlikely to be open to persuasion to return and that it is better to focus on recruitment (DoH, 2003b). In their reflections on leaving, participants show a complex attitude towards this possibility. Their continued attachment to nursing may mean that some leavers are open to returning but, as Elizabeth shows, it is not enough to make returning easy by means of refresher courses and family friendly policies. Attention also needs to be paid to the reasons why nurses leave and what is needed in order to make the work itself an attractive prospect once more.

The need for a shift in policy related to leaving nursing is a key aspect of the following chapter in which I draw together the various strands of the analysis presented in this thesis, highlighting the key themes that have arisen. I follow this with an exploration of the limitations of the study, of the areas for further research that it points to and the implications of the findings for those in nursing, in management and in policy making arenas.

# Chapter Seven

## Conclusions

At the inception of this study I set out to establish why so many nurses choose to leave nursing, and to describe the thoughts and experiences that lie behind their decisions. However, study of the available statistics and literature revealed that, although there are clear problems with high levels of dissatisfaction and a desire to leave, the actual 'exodus' of nurses is based more on assumption than on evidence. Indeed, a more pertinent question would be: Why do nurses stay? This finding highlighted the need both for more accurate statistical descriptions of current trends within the nursing workforce, and for research that identifies and clarifies the issues behind these trends. Consequently, the focus of this study shifted towards the latter aim, asking what meaning leaving has for nurses and how this shapes their responses to dissatisfaction. The result is a rich and complex thesis that paints a broad view of what it is to be a nurse in the British NHS in the early twenty-first century. This serves as a context within which the inter-related phenomena of leaving and staying can be understood as part of nurses' responses to dissatisfaction.

Within this study, leaving emerges as one possible option among a range of possibilities for dissatisfied nurses and is generally a measure of last resort. Understanding this phenomenon requires a consideration of the broad range of practical, emotional and social factors shaping the choices that nurses perceive as being acceptable or possible solutions to their dissatisfaction. It requires analysis of individual accounts within the context of the current occupational discourse of nursing and the political economy of healthcare. Rather than asking: Why do nurses leave? I have asked: What prompts nurses to consider leaving? What does the idea of leaving mean to nurses? What influences their willingness to consider or choose this option? Why do some act on their desire to leave while others stay? What other alternatives do dissatisfied nurses have?

In this chapter I attempt to draw out of the complex description of nursing contained within this thesis an overview of the key themes and implications of the study. I begin by arguing that nurses' dissatisfaction and distress is rooted in the context of the struggle to shape healthcare and nursing, within which they are relatively powerless players. I describe the implications of this for both nurses and nursing before explicating the various meanings that leaving carries for individual nurses within this context. I then explore the limitations of the study, identifying potential avenues for further research, before setting out the implications of the study for policy makers and managers, for nurses and nursing.

## **A CONTEXT OF STRUGGLE**

### **NEGOTIATING FROM A POSITION OF WEAKNESS**

A key point that this study highlights is that there is not a simple set of grievances that can be identified and addressed in order to improve morale, recruitment and retention in nursing. Rather, the search for answers needs to be rooted in an awareness of the complex interplay of factors that make nursing such a challenging and difficult role to fulfil. At the national level, nurses as a group tend to be sidelined from positions of power that shape the delivery of healthcare and the form of nursing. This arises from a range of factors including the gendered nature of nursing as a caring profession dominated by women. As I showed in chapter five, such work tends to be devalued by non-nurses due to its dirty nature and the assumption that it is based in a natural and feminine aptitude for caring rather than in skill and knowledge. For nurses, the connections between nursing and broader gender discourse manifest as a lack of assertiveness and difficulties in defining and explaining their role in terms that are comprehensible within the masculine language of work and skill. As an occupational group that has grown in the shadow of medicine, and that continues to reflect ideals of submissive obedience, nursing does not have a strong platform from which to promote its ideals and shape its own practice. The power that nurses could wield is undermined by fear and a lack of confidence in the value of what they do. Consequently, there is a

tendency among nurses to accept the *status quo* as undesirable but inevitable and to respond as powerless individuals rather than as a powerful group.

This weakness at the group level impacts upon individual nurses for whom the workplace is the setting of a daily struggle between stakeholders to define the nature and organisation of healthcare. It is where national and local policies translate into concrete practices, and where the roles and responsibilities of all concerned have to be negotiated and re-negotiated through daily actions and interactions. It is also an intensely complex social setting in which people with very different interests, ideals and needs come together in situations characterised by high expectations, high levels of emotion and potentially serious consequences when things go wrong. Within this context individual nurses often lack the power or assertiveness to translate their high ideals into practice and to set professional and personal boundaries that limit the demands that are made upon them. This relative lack of power may be compounded by feelings of fear or of complete powerlessness and fatalism arising from the subservience that persists in nursing discourse, or from repeated experiences of failure.

Nurses' relative lack of power to shape their work often manifests as a tension between negative feelings of fear, frustration and anger, and positive feelings of enjoyment, commitment and passion for their work with patients. The inherent stress of nursing is compounded by the more stressful imperative to find ways or spaces in which they can fulfil their ideals and obligations and achieve satisfaction at work. Some are successful in this endeavour and do find satisfaction while others continue to struggle or choose to leave nursing altogether.

The provision of healthcare is a highly political arena resulting in a constant state of change as the balance of power shifts between groups with competing ideologies. Over the past three decades the key site of struggle has arisen from the conflicting discourses of industrial versus humanistic healthcare that I described in chapter three. In its most extreme form, the industrial discourse is characterised by a concern with organisational efficiency and cost, and the setting and meeting of targets. Within this discourse, patients and staff alike are transformed into units of production to be described and managed in statistical terms. On the other hand the humanistic discourse is characterised by a concern to provide a service that meets the human needs of individual patients, at times regardless of the financial cost or



complexity of organisation involved. These discourses are not exclusively associated with particular stakeholders. For example, politicians and managers may speak of meeting targets as a means of improving patient care, while nurses may choose to organise their work in ways that fragment and dehumanise patients in order to protect themselves emotionally or simply to get through the day's work. Furthermore, the clash of discourses is complicated by the tendency within nursing to stress the importance of treating patients as whole people whilst denying their own humanity.

Rather than being a confrontation between advocates of two opposing extremes, the struggle between discourses manifests as an imbalance in their relative influence. Over the past twenty years, the industrial discourse has gained ascendancy with the increased marketisation of the NHS. The politicians and managers, who constitute the most powerful stake-holding group, are physically and emotionally more distant from patients and tend to take the broader view of trends and economics, softened with the rhetoric of care. Nurses, who are physically and emotionally close to individual patients, but often have little to do with the economics and organisation of the service, tend towards the humanistic ideal, tempered by the practical need to manage large numbers of patients and relatives. Problems arise for nurses because their relative lack of power compared to politicians and managers means that the big decisions regarding organisation and finance tend to reflect the larger scale, industrial perspective. This translates into difficulties in achieving the ideal of holistic, patient centred care in workplaces where staffing and resources are geared towards maximum efficiency or minimum cost.

### **LIMITED POWER, LIMITLESS BOUNDARIES**

The difficulties encountered by nurses in achieving their ideals, with limited power and within the constraints of existing resources and structures, are exacerbated by a powerful nursing discourse of high standards, self sacrifice and hard work that militates against the setting of limits or boundaries. In chapters three, four and five I described how nurses work within an occupation that is characterised by a lack of boundaries. The dominant discourse that shapes nurses' expectations and aspirations is one that shows no recognition of the bounds of possibility. A holistic understanding of nursing creates the potential for a workload without limits.

Extremely high expectations in terms of the standard of care provided create a situation in which a nurse can never work hard enough. A discourse of total commitment presumes that nurses have no other life beyond their work, and that they possess a limitless capacity to endure.

The ideal to which nurses are expected to aspire is not a human one. It more closely resembles the child's view of a teacher who only exists in her working role, returning to her box when she is no longer needed. A child expresses surprise at seeing her teacher in the supermarket or cinema, or when she complains of a headache. Similarly, the idea that a nurse has family commitments or becomes tired and unwell as a result of the pressure she is placed under often generates surprise and condemnation.

These boundless expectations create a situation in which nurses place an impossible burden on their own shoulders and on those of their colleagues. The power of this discourse is such that few nurses feel able to challenge it, to negotiate the boundaries of their workload, to limit the hours they work, or to control the personal sacrifices they are expected to make. They are faced with the impossible choice between negotiating boundaries in order to protect themselves and their patients, or maintaining their status as 'good nurses'. When they do decide to challenge the discourse they take on not only their own colleagues but also a powerful system that is constructed on the assumed existence of a compliant and hard working workforce.

Although fear and idealism are important foundations for this discourse of the super-nurse, its continued power is not simply a reflection of the behaviour and feelings of nurses. It provides the ideal situation for employers to exploit nurses' willingness to work hard and endure whatever is expected of them. As such, it serves the interests of, and is encouraged by, an NHS that is currently under enormous pressure to provide high quality healthcare within tight budgetary constraints. Within this context, nurses who wish to challenge both their own occupational discourse and its exploitation by other groups often lack the power and confidence to succeed.

## **LIVING IN A STATE OF TENSION**

In this thesis I describe nursing as an extremely challenging occupation whose members are required to constantly negotiate and re-negotiate their role and contribution within the workplace in complex and contested situations from positions of relative powerlessness. This creates a constant tension between nurses' aspirations and their ability to achieve their goals. Many find themselves torn between the desire to leave and an inability or unwillingness to do so. On the one hand their commitment to patients and their high ideals, combine with the potentially powerful rewards of the job, a powerful discourse of strength and self-sacrifice, and an inability to envisage any alternative career path to hold them within nursing. On the other hand, the high emotional and physical costs to themselves and their families combine with a commitment to self-preservation and to maintaining standards for patients and for the good name of the profession, prompting the desire to leave nursing. Living with this tension can have high personal costs in terms of both mental and physical stress and distress, appearing in the statistical descriptions of NHS nursing as high levels of sickness absence or psychological illnesses such as depression, burnout and even suicide. From the beginnings of their careers nurses need to either find ways of dealing with this tension or to find spaces in which they can fulfil their expectations of the job.

## **RESPONDING TO STRESS AND DISSATISFACTION**

In the first instance, nurses are taught the importance of coping and learn a variety of strategies that help them to manage difficult situations. These can be effective in the short term but longer-term problems prompt many to change posts in search of situations that facilitate the achievement of their ideals. The high level of turnover that these moves contribute to has been described as a good indicator of the level of conflict within an organisation (Watson, 2001). Sometimes moving on is all a nurse needs to do to find satisfaction since the ethos, resourcing and organisation of workplaces varies. However, since similar problems appear across the UK, changing post does not provide the answer for many nurses who find themselves in a similar position wherever they go. In this situation, many nurses re-train, seeing in a new speciality the opportunity to practise nursing as they envision it. If this major investment of time, effort, and often money, does not pay off, they may begin

to lose hope in finding satisfaction. It is this loss of hope that appears in many leavers' accounts of their experiences. Others lose hope but see no way out, becoming trapped and at risk of burnout, or investing their commitment outside of work and viewing nursing as 'just a job'.

## **THE MEANING OF LEAVING**

Within this context, leaving can have a variety of meanings. For those nurses who do find satisfaction, or who are immersed in the dominant discourse of the super-nurse, leaving may be understood as an indicator of a lack of commitment or weakness in colleagues. However, there is no evidence from this study that leaving is an indicator of either characteristic among those leavers interviewed. For them leaving is a measure of last resort after all other acceptable avenues have been explored. It is a difficult choice to make emotionally and may have serious practical and financial implications. Some nurses who make this decision find it too hard to sustain and return to nursing at a later date. Others work as agency or bank nurses in order to wean themselves away from the nursing identity or from financial dependence on nursing. This option provides them with a greater sense of control over their working hours and conditions, with less responsibility and minimal engagement with the politics of the workplace.

For those who leave, leaving may carry any one of a number of meanings. It may be the concrete representation of an unbearable sense of hopelessness and powerlessness. Alternatively the nurse concerned may be making a more positive statement of personal power and worth, saying that she is worth more than this and can find fulfilment elsewhere. This response to dissatisfaction echoes a phenomenon described among navvies by Sykes (1969). He argued that 'jacking', or leaving suddenly and for no apparent reason, was a statement of their freedom and independence from employers and of their hostility towards employers in general. A nurse who chooses to leave nursing may also be making a statement about her commitment to patients or to her profession, refusing to accept what she judges to be unacceptably low standards that endanger or denigrate patients as people or that damage the credibility of nursing itself.

The meaning that leaving carries varies between nurses, reflecting their individual perspectives on nursing and their place within it. What emerges from this study is the shared sense of commitment among participants whether they are 'stayers' or 'leavers'. It is not a simple matter of the degree of commitment that determines whether a nurse stays or leaves. Rather it is a complex interaction between several factors. These include the degree to which she identifies with the dominant discourse of strength and self sacrifice, her ability or willingness to challenge this discourse, her sense of self worth and confidence, the focus and nature of her commitment, whether or not she is able to fulfil her expectations, whether she sees any prospect of being able to do so in the future, the sources of support that are available to her and whether she is willing to make use of them, the alternative career choices that she perceives as being available and acceptable, her financial situation and personal commitments.

The complexity of these factors and their interactive nature, combined with the intensely personal nature of some, mean that there is little value in trying to predict who is likely to leave nursing and who will continue to nurse regardless. A more fruitful approach to resolving the problems within the nursing workforce lies in addressing the issues that underpin nurses' dissatisfaction and desire to leave and their ability to respond effectively to these issues without resorting to leaving. This depends upon a thorough understanding of these issues and their links to leaving to which I hope this thesis contributes. In the following section I identify some of the limitations of this study and the potentially useful lines of enquiry that it opens which could further our understanding of current problems in the nursing workforce.

## **LIMITATIONS OF THE STUDY AND OPPORTUNITIES FOR FURTHER RESEARCH**

In any study there are limits to the answers that a researcher can provide and those that are offered provide pointers to the need for further enquiry. As such, the limitations of a study are also opportunities for further research. In this study I do not claim to provide all the answers and explanations for the current problems

within the NHS nursing workforce. Instead I present a broad picture within which the phenomenon of leaving nursing can be contextualised and that provides a springboard for further, more detailed research and debate.

As I argued in chapter two, the purpose of this thesis is to provide a better understanding of leaving nursing which can both stimulate further research and provide a more informed basis for policy. In this section I identify some of the potentially fruitful lines of enquiry raised, some of which relate to specific issues such as leaving nursing or the discourse of the super-nurse, others reflect the broader themes that are identified such as nurses' power to shape their working lives. This area and other sociological phenomena within nursing have been the subject of many previous studies. However, the recent focus on funding clinical nursing research rather than sociological studies of nursing means that there is a need to update and synthesise existing work and to relate it more specifically to the issues of morale, sickness, turnover and wastage.

#### **UNDERSTANDING NURSING AS 'JUST A JOB'**

In addition to the limited depth that can be achieved in a study of this scope, my findings are also confined by their unavoidable basis in the accounts of nurses who care enough about their work to either consent to be interviewed or to write about it. It is neither possible nor ethical to force people to participate in research and unwilling conscripts are unlikely to contribute meaningfully to the in-depth interviews required. This raises the questions: Are there large numbers of nurses who really don't care? What are the experiences and feelings of those for whom nursing is 'just a job'? It may be possible to find answers to these questions through participatory research, working alongside nurses, identifying and interacting with those who appear not to share the enthusiasm and engagement shown by participants in this study.

#### **UNDERSTANDING THE GENDERED CONSTRUCTION OF LEAVING NURSING**

In this thesis I note that, in contrast with common-sense understandings, male participants seem to share many of the basic values and ideas of their female colleagues. However, male nurses' perspectives will inevitably differ in some

respects simply as a function of their 'otherness' in a female dominated profession. Differences are likely due to the different pressures and expectations placed upon men and women and variations in their economic position in society. Further research is needed in order to understand if or how male nurses' construction of nursing differs from that of female nurses. The questions that need to be asked include: How do men experience and understand the issues discussed by female nurses in this study? Is their orientation towards, and experience of leaving different? Do they view the skills they possess, and therefore the alternative opportunities available to them differently?

### **UNDERSTANDING POWER IN NURSING**

Although there is a generous body of literature exploring the issue of power in nursing, and in particular the relative positions of doctors and nurses, there is a lack of work demonstrating explicitly how these power dynamics relate to the issues faced by the nursing workforce, or the orientation of individual nurses towards leaving. Further research is needed in order to understand the experience and exercise of power at both the professional and individual levels and how this relates to the perceptions and actions of other groups with whom nurses interact.

At the group level there is a need for work that explores the role and influence of nurses within the decision-making arenas of local and national policy. How do nursing leaders understand their position and influence? What do they expect to achieve? To what extent are they included in policy development? What degree of influence do they have and how do they function within this arena? How do other key contributors view these nurses and interact with them?

Within the clinical setting there is a need to explore in more depth individual nurses' perceptions and experiences of their own power to shape their daily practice and the structures within which they work. How do the actions and words of their leaders shape these thoughts and experiences? To what extent do practising nurses exercise the power that they do have? How do they achieve this in multidisciplinary settings? In areas such as community or specialist nursing there is a valuable opportunity to explore the ways in which nurses exploit unclear boundaries in order to achieve their ideals.

## **UNDERSTANDING THE DISCOURSE OF THE SUPER-NURSE**

The other key theme in this thesis that merits further detailed study is the discourse of the super-nurse. This discourse lies at the heart of nurses' dissatisfaction and their difficulties in finding ways of dealing with it that do not involve risking condemnation or leaving nursing entirely. If this discourse is to be challenged and replaced with the idea that nurses are also people who matter we need a deeper understanding of the reasons for its continuing presence and influence over nurses' expectations. Fruitful lines of enquiry in this area include investigations into the background and motivation of those entering nursing. In particular there is a need for research into the possibility that many nurses come from backgrounds in which early responsibility for the care of others, or traumatic personal experiences have established a deep identification with the role of carer and difficulties in recognising or accepting their own vulnerability. Another potentially valuable line of enquiry lies in the experiences of nurses as patients: are the stories of neglect told by nurses in this thesis unusual or is this a common experience for nurses? If the latter is true there is a need to highlight this tendency in order to ensure that nurses and their families receive the care that all other groups expect. Research into the attitudes and experiences of both nurses as patients and nurses caring for other nurses would be valuable in this respect.

## **UNDERSTANDING THE ROLE OF MATERNITY LEAVE**

In addition to the need for further research into the broad themes of power and discourse this thesis points to the need for studies that illuminate the process by which nurses reach their decisions to stay or to leave. In particular there is the question of the opportunity that maternity leave provides for nurses to reflect on and re-assess their work and identity as nurses. Questions that arise include: Are there major changes in nurses' orientation towards their work during this period away from work? How do the concrete experiences of returning to a previous post or being moved to a new one affect their perspectives? How do the attitudes and actions of employers and colleagues around the time of new motherhood impact on nurses' attitudes and choices? Work with nurses who have chosen not to return,



and with those who combine nursing with new parenthood, would provide important information in this area that could guide both NHS policy decisions and attempts from within nursing to foster a culture that supports working parents.

## **IDENTIFYING THE DESTINATIONS OF LEAVERS**

In chapter one I described a situation in which there is a serious lack of data describing the interconnected phenomena of wastage and turnover in NHS nursing. In addition to the need for detailed statistical data regarding the destination of leavers there is a need for more accurate accounts of the reasons for these choices. As I argued in chapter one, if exit interviews are to provide any meaningful answers they need to provide leavers with the opportunity to discuss their decisions openly without fear of the consequences. This will require the employment of independent researchers, conducting confidential interviews in which leavers feel safe to discuss their thoughts and experiences. Furthermore, they need to believe that their answers will be heard and will make some difference to the patients and colleagues that they are leaving behind. Within the climate described in this thesis, nurses are unlikely to give honest, detailed answers to people employed by their managers, or to provide the necessary detail in response to surveys.

The need for further research into the destinations and motivations of leavers is also indicated by Jean's suggestion that some qualified nurses choose to demote themselves and work as HCAs. This is a radical step to take in order to achieve one's ideals and, if true, indicates the depth of frustration felt and the need for action to retain these nurses. Furthermore, if this pattern is occurring on a large scale it is a waste of the training and skills of those involved and a drain on the resources of the NHS.

In this thesis I have chosen an approach that seeks to explain current trends within the nursing workforce by situating the accounts of individual nurses within the context of their production. In so doing I shift attention from the need to develop predictive and explanatory models of poorly described trends, towards the need for a deeper understanding of the phenomena of staying and leaving. In line with this

shift of emphasis, the implications of this study, which I explore in the following section, lie not in specific policies, but in the need for further research and debate, and for shifts in current ways of thinking both in nursing and policy/management circles. These underlying shifts are necessary precursors to the development of effective policies.

## **IMPLICATIONS OF THE THESIS**

In this section I outline the implications of this thesis for those working in the two key fields of policy and nursing, whether as leaders, as those tasked with implementing organisational change, or as those directly providing the service to patients. In each context there is the need for a shift in the way of understanding and responding to the nursing role and the part that nurses play in the delivery of healthcare. There is also the need for a reassertion of the humanity of all those involved in the delivery and receipt of healthcare and of the ethic of care based in the principle that people matter.

### **IMPLICATIONS FOR POLICY MAKERS AND MANAGERS**

Although workplaces vary, this thesis paints a picture of an NHS in which nurses are frequently dehumanised, are excluded from decision making and don't feel recognised or valued as knowledgeable and skilled professionals. This situation alienates and demoralises a workforce that continues to be characterised by a passionate desire to do a good job. Consequently the quality of care that they provide is diminished through the structural constraints of inadequate resources, organisational factors that obstruct rather than facilitating their role, and a loss of staff and of the enthusiasm and effort of some of those who remain. In addition to the impact of this situation in terms of quality, there are also significant costs in terms of organisational efficiency and economics.

A key source of nurses' dissatisfaction lies in their belief that patients are not objects to be processed but are all unique individuals with different needs and different ways of responding to treatment. As such they cannot be cured or cared for on the basis of one protocol fits all. Their recovery depends to a significant extent on

recognising and responding to this human variation and on fostering patients' feelings of security and confidence in their carers and the system to which they trust themselves. Equally, nurses are not interchangeable mechanical units completing clearly defined and discrete tasks. They are people with skills and knowledge engaged in complex work that depends upon teamwork and adequate support mechanisms. The quality of their work depends not on the efficiency of their deployment and accuracy of routinised instructions, but on systems that facilitate the exercise of their knowledge and skills and the provision of a working environment that makes them feel valued and supported.

The need to change the current working environment is driven not just by issues of quality of care for patients or the welfare of nursing staff. It is also driven by the considerations of economics and efficiency that dominate the NHS. However, there appears to be little recognition that a demoralised and frustrated workforce, whose role is poorly understood by those with the power to shape their work, is likely to display high levels of sickness absence, turnover and wastage and is unlikely to work efficiently or effectively.

In order to develop effective policies that address the concerns described in chapter one there is a need to balance the industrial concerns of efficiency and effectiveness with the humanistic imperative to recognise the humanity of those within the system. Policies based in such a balance of considerations are likely to have benefits in both human and economic terms and to produce a more effective NHS. There are certain key areas in which policies based in such a balance are likely to produce the greatest impact. The first of these involves replacing the current Taylorist approach to organising nurses' work and the setting of staffing levels with systems that are based in a sound understanding of the role of nurses within the healthcare team as described in chapter three. The second is to focus attention on the importance of building and maintaining strong, stable, supportive nursing teams. Once again this requires investment in increased staffing levels to enable nurses to spend time communicating with each other, as well as a reduction in the destabilising use of agency and bank staff. At present, increases in staff pay bills tend to be viewed as undesirable, as can be seen in recent news reports that identify pay rises and 'workforce reforms' as 'among the biggest drains on resources' (BBC, 2005e). This orientation towards employees is common within the Anglo-American

culture of work and does little to boost staff morale. A more positive orientation would involve putting the principles behind the award *Investors in People* into practice, viewing spending in this area as an investment rather than a drain. This would have the double impact of improving nurses' ability to fulfil their role through increased resources and improved training, and of improving morale by making them feel valued and supported.

All of these changes outlined above depend upon another fundamental shift in thinking within management and policy circles. That is, the need to recognise, understand and value the role that nurses perform. This, in turn depends on communication across the present gulf between the two groups. I address the role that nurses need to play in achieving this below, but managers and policy makers need to provide nurses with the opportunities and encouragement to contribute to the decision making process at all levels and then to listen to and value what they say. Valerie's experiences as a manager, described in chapter six, suggest that nurses have the knowledge and skill as well as the enthusiasm to find solutions to local problems in particular and to improve their practice when given the necessary opportunity, resources and support.

At the heart of these changes lies the need for managers and policy makers to recognise, value, trust and harness nurses' enthusiasm for their work, their knowledge and skills and their unique insights into the day-to-day workings of the NHS. However, managers and policy makers cannot make these changes alone and there is also a need for nurses to share this understanding, recognition and trust in their own contribution.

## **IMPLICATIONS FOR NURSES AND NURSING**

In chapter two I referred to Dingwall and Allen's (2001) suggestion that nurses' unrealistic idealism is at the root of their alienation, and that the answer lies in focusing on working within the system as it is. However, in this study I show that such a course is neither possible nor desirable since it is nurses' idealism that sustains them in difficult circumstances, and that prevents the dehumanisation of patients, which can be a dangerous as well as an unpleasant experience. For nurses and nursing the key implications of this thesis rest on the maintenance and

promotion of these ideals, albeit tempered with a greater degree of realism that sets boundaries to the realms of possibility. These implications fall into three main areas that correspond with and reinforce the recommendations made by Tschudin in her book *Nurses Matter* (1999). First, there is a need for nurses to apply the ethic of care, and the principle that people matter, to themselves as well as to patients. Second, there is a need for nurses to understand and value the vital role that they play in the healthcare team and the high level of skill and knowledge involved in 'basic' as well as technical nursing. Third, there is a need to challenge the feeling and experience of powerless among nurses so that at every level they are able to describe and promote their role to non-nurses. This is particularly important in both the local and national arenas where decisions are made that shape the structure, organisation, funding and delivery of healthcare.

### **Challenging The Discourse of The Super-Nurse**

The first challenge for nursing lies in confronting a powerful occupational discourse that imposes unrealistic and damaging expectations upon nurses. The way in which so many participants in this study challenge this dominant discourse within the safe environment of their interviews, whilst outwardly conforming, begs the question of whether it really reflects the ideas of the majority. It is possible that an old and outdated set of expectations is perpetuated by the actions of a small number of nurses, and a fear that prevents others from taking the risk of being labelled 'weak' or a bad nurse. If enough nurses voice their dissent, the power of this discourse may disappear and they may be able to combine their voices to make themselves heard. Until this happens, it seems unlikely that nurses will be able to support each other and work together to contribute meaningfully to the decisions that are made about their work.

### **Understanding And Valuing The Nursing Role**

In this thesis I describe a situation in which many nurses, even in academic circles, struggle to describe the nursing role. As a result the core skills of communication, observation, analysis and management that lie at the heart of 'basic nursing' are frequently dismissed in favour of a concern to promote the technical skills and

medical knowledge that carry more status in the masculine sphere of work. This finding supports Callaghan's argument that non-nurses are unlikely to value nursing until nurses themselves do so (Callaghan,1989). If nurses are to be successful in promoting the value of their contribution to healthcare there is a need for a shift of emphasis towards these core skills and the vital connective and humanising function of nursing. This will require further research and debate that extends beyond academia to shape the understanding and raise the self-esteem of nurses as individuals and as a group.

### **Empowering Nurses**

The term empowerment is one that is frequently overused in its application to nurses, prompting those who feel their lack of power to scoff at its use as insincere. However, the problem lies not in the concept itself but in a continuing failure to translate the rhetoric into practice. The empowerment of nurses is a need that infuses this thesis and is a basic requirement if the changes described above are to be achieved. Nurses' disempowerment lies at the heart of their frustration and distress and prevents them from translating their anger and passion into positive action to remedy the difficult and often damaging situations in which they work. If nursing is to be transformed into a profession that values and supports its members as people, and if it is to convince others of its value, there is a basic need to empower nurses. This requires action on two main fronts: first in improving our understanding of the nursing role and nursing knowledge and skill; second on the provision of encouragement, opportunity and skills in speaking out that will enable nurses to contribute to debate in all spheres, from informal contacts with patients, friends and family to formal discussions in the workplace, in Trusts and at the highest level of policy making.

## CONCLUSIONS

Although there is little evidence to support the assertion that nurses are leaving in large numbers, the research indicating high levels of a desire to leave, and of high sickness absence in a culture that stigmatises physical and emotional weakness, is a sign that there is a serious problem in the NHS nursing workforce that needs to be addressed. Given the strength of the super-nurse discourse, the marginal position that nurses hold, the divisions between different interest groups and nurses' deeply rooted feelings of powerlessness and ambivalence towards the exercise of power, addressing these issues is an enormous challenge for the profession. However, unless it is attempted there seems to be little likelihood that there will be sufficient motivation or a deep enough understanding of nursing among policy makers and managers to address the issues raised in this thesis.

The challenge set in this thesis for those in policy and management circles is to develop policies that find a balance between the demands of the industrial and the humanistic models of healthcare, that are based on an understanding of nurses' experiences and attitudes towards their work, and that will enable those who are unhappy to stay, those who are trapped to find satisfaction in their work again, and that will make nursing in the NHS an attractive option for those who have already left. The challenge posed to nurses is to better understand and value themselves and their profession and to convey this to the non-nursing world.

# APPENDIX ONE: OVERVIEW OF THE SOCIO-POLITICAL CONTEXT OF THE STUDY

This table is divided into three key arenas in which changes have occurred in recent years, i.e. the political economy of health, the NHS, and the nursing profession. Within each arena I identify particular issues, such as demographic change, within which general trends can be identified. These are set out alongside formal policy and other informal responses to these trends. I also include some past events such as the 1972 Briggs report and the health reforms of the 1990s, the impact of which is still being felt today. The contextual details offered above necessarily provide a simplified and abbreviated account of the changes affecting nurses' understanding and experience of their work in the past decade or more. As this thesis demonstrates, the creation of a new policy does not guarantee its success, and it is extremely difficult to establish with certainty the causal links between policy change and changes in practise and experience.

Area of Change	Trends	Formal and Informal Responses within Government, the NHS and Nursing
<i>The Political Economy of Health</i>		
Demographic change	An aging population places more pressure on the NHS.	1990 Community Care Act. Leads to the closure of long-term wards, and a shift of emphasis towards early discharge and community-based health care.  2004, Public Health White Paper, 'Choosing Health', currently passing through Parliament in Westminster. Reflects a shift of emphasis towards health education and meeting public health targets.



Area of Change	Trends	Formal and Informal Responses within Government, the NHS and Nursing
	The traditional recruitment pool of female school leavers is drying up, contributing to nursing shortages.	<p>Annual recruitment campaigns with a shift of emphasis towards overseas recruitment.</p> <p>1999, a new Recruitment and Retention Unit is established in the DoH</p> <p>Return to Practice campaigns from 1999-2005 (DoH, 2005c).</p> <p>2004, Agenda for Change introduces changes in pay and grading designed to enhance the retention of nursing staff.</p>
Political Change	Devolution in 1999.	Responsibility for health, social and educational policy devolved to the Scottish Parliament, Welsh Assembly and Northern Irish Department of Health, Social Services and Public Safety (DHSSPSNI).

Area of Change	Trends	Formal and Informal Responses within Government, the NHS and Nursing
Changing expectations and working patterns, particularly for women	<p>Broader opportunities for women create competition for recruits and contribute towards the nursing shortages.</p> <p>Higher career expectations among women and more general changing expectations regarding work with a move towards career pathways rather than a single career for life.</p> <p>A greater proportion of women in the workforce and more part time workers.</p>	<p>See above re. recruitment and retention</p> <p>2004, Agenda for Change introduces changes in grading structure.</p> <p>Expansion of specialist nursing posts in the early 21<sup>st</sup> century. Introduction of 'modern matrons' (2001) and 'Maxi-Nurses (2005).</p> <p>Plans for training structures that enable people to switch to another profession more easily.</p> <p>Emphasis on family friendly policies such as job sharing, flexible working and childcare, seen in Improving Working Lives, (2001).</p>

Area of Change	Trends	Formal and Informal Responses within Government, the NHS and Nursing
The rise of consumerism	<p>Increasing pressure to spend and therefore earn more.</p> <p>Increasing house prices add to pressure on earnings and exacerbate regional nursing shortages.</p> <p>Increasing emphasis on patients' rights, involvement in care, informed consent etc.</p>	<p>Ongoing debates regarding pay</p> <p>2002, introduction of new post of NHS housing co-ordinator.</p> <p>2002, building of prefabricated homes for nurses in London.</p> <p>1991, Patients' Charter.</p> <p>2003, introduction of Patients' Advice and liaison Service (PALS)</p>
Increasing power of the European Parliament to shape working practices in Britain	Regulation of Working Practices	<p>2003, Reduction in Junior Doctors' Hours.</p> <p>Family Friendly Policies such as Improving Working Lives (2001).</p>
<b>The NHS</b>		
Marketisation	Introduction of competition to the NHS and changing priorities in the 1980s and 1990s with an increased emphasis on value for money and efficiency.	<p>1992, creation of competing NHS Trusts.</p> <p>1983, introduction of competitive tendering for services.</p> <p>Ongoing throughout this period: 'Efficiency Savings' made by reducing shift overlap time, increasing bed occupancy rates etc. which intensifies nurses' workloads further.</p>

Area of Change	Trends	Formal and Informal Responses within Government, the NHS and Nursing
Managerialism	<p>Shift of power away from professionals to managers.</p> <p>Taylorisation of work place with emphasis on a flexible workforce, the division of labour into measurable tasks and work guided by protocol rather than professional judgement.</p> <p>Trend towards charge nurses adopting managerial rather than clinical leadership roles.</p>	<p>Begins in 1970s with the Briggs Report but continues to intensify to the present day.</p> <p>1988, introduction of National Vocational Qualifications (NVQ) Scottish Vocational Qualifications (SVQs).</p> <p>2000 onwards:</p> <p>introduction of integrated workforce planning and the development of national workforce databases.</p> <p>introduction of generic workers and Health Care Assistants (HCAs)</p> <p>rise of agency usage and creation of <i>NHS Professionals</i> in England in 2003.</p> <p>2000, Charge nurses placed in control of ward budgets.</p>
The Rise of Technology	<p>Rise of multi-national corporations seeking new markets by developing new drugs and equipment.</p> <p>Increasing use of information technology.</p>	<p>Both phenomena contribute to the escalating cost of health care and a greater need for staff training.</p> <p>Reorganisation of working practises and creation of new roles.</p>

Area of Change	Trends	Formal and Informal Responses within Government, the NHS and Nursing
Nursing		
Changes in the nursing role	Expansion of the nursing role and increasing specialisation in response to the opportunities provided by the reduction in junior doctors' hours and the moves towards a more flexible workforce.	<p>Expansion of specialist nursing posts in the early 21<sup>st</sup> century. Introduction of 'modern matrons' (2001) and 'Maxi-Nurses (2005).</p> <p>Around 2000, introduction of training in new roles e.g. minor surgery.</p> <p>1998, introduction of nurse prescribing.</p> <p>Intense debates regarding direction and scope of nursing role.</p>
Changes in nursing practice	Increasing emphasis placed on accountability and evidence based practise, linked to the rise of the professional discourse from the 1970s onwards. This can also be linked to the Taylorisation of the NHS with its emphasis on following protocol.	<p>Nursing process developed in the USA in the 1970s and adopted in Britain in the 1980s.</p> <p>Increasing emphasis on nursing research as the basis for practice since the Briggs Report in 1972.</p> <p>PREP (1992) includes the need for regular reviews of each nurses' efforts to sustain continuous professional development.</p> <p>Changes in the recording of working practise, often involving an increase in paperwork.</p> <p>The introduction of IT systems has the potential to facilitate nurses' practise, but staff also have to cope with the teething problems of this transitional period.</p>

Area of Change	Trends	Formal and Informal Responses within Government, the NHS and Nursing
Changes in nurse education	Movement of nursing into the arena of higher education increases nurses' career expectations and creates the demand for further training and new career possibilities.	<p>Introduction of Project 2000 in 1992.</p> <p>Introduction of PREP. In 1992 marks a shift towards continuous learning and development.</p> <p>Expansion of specialist nursing posts in the early 21<sup>st</sup> century. Introduction of 'modern matrons' (2001) and 'Maxi-Nurses' (2005).</p>

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